| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *CMBD-126734449* | *State:* | *Arkansas* |
| *Filing Company:* | *Combined Insurance Company of America* | *State Tracking Number:* | *46289* |
| *Company Tracking Number:* | *14910-AR-A ET AL* | | |
| *TOI:* | *MS08I Individual Medicare Supplement - Standard Plans 2010* | *Sub-TOI:* | *MS08I.001 Plan A 2010* |
| *Product Name:* | *Senior 2010 Medicare Supplement Policies- Plan A et al* | | |
| *Project Name/Number:* | *2010 Medicare Supplement Policies- Plan A et al/14910-AR-A ET AL* | | |

## Filing at a Glance

Company: Combined Insurance Company of America

| | | |
|---|---|---|
| Product Name: Senior 2010 Medicare Supplement Policies- Plan A et al | SERFF Tr Num: CMBD-126734449 | State: Arkansas |
| TOI: MS08I Individual Medicare Supplement - Standard Plans 2010 | SERFF Status: Closed-Approved-Closed | State Tr Num: 46289 |
| Sub-TOI: MS08I.001 Plan A 2010 | Co Tr Num: 14910-AR-A ET AL | State Status: Approved-Closed |
| Filing Type: Form/Rate | | Reviewer(s): Stephanie Fowler |
| | Author: Sue Thill | Disposition Date: 08/03/2010 |
| | Date Submitted: 07/22/2010 | Disposition Status: Approved-Closed |
| Implementation Date Requested: 06/01/2010 | | Implementation Date: |

State Filing Description:

## General Information

Project Name: 2010 Medicare Supplement Policies- Plan A et al
Project Number: 14910-AR-A ET AL
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 08/03/2010

Deemer Date:
Submitted By: Sue Thill
Filing Description:
Combined Insurance Company of America
FEIN Number 36-2136262
NAIC Number 626-62146
Form Numbers:
14910-AR-A - Medicare Supplement Policy (Plan A)
14911-AR-F - Medicare Supplement Policy (Plan F)
14912-AR-N - Medicare Supplement Policy (Plan N)

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 05/08/2010
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 08/03/2010
Created By: Sue Thill
Corresponding Filing Tracking Number:

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|---|---|---|---|
| *SERFF Tracking Number:* | *CMBD-126734449* | *State:* | *Arkansas* |
| *Filing Company:* | *Combined Insurance Company of America* | *State Tracking Number:* | *46289* |
| *Company Tracking Number:* | *14910-AR-A ET AL* | | |
| *TOI:* | *MS08I Individual Medicare Supplement - Standard Plans 2010* | *Sub-TOI:* | *MS08I.001 Plan A 2010* |
| *Product Name:* | *Senior 2010 Medicare Supplement Policies- Plan A et al* | | |
| *Project Name/Number:* | *2010 Medicare Supplement Policies- Plan A et al/14910-AR-A ET AL* | | |

149276-AR - Application
014910 - Outline of Coverage
RN031020R - Replacement Notice
7020-AR - Rate Sheet for Plan A (Preferred Rates)
7021-AR - Rate Sheet for Plan F (Preferred Rates)
7022-AR - Rate Sheet for Plan N (Preferred Rates)
INDIVIDUAL MEDICARE

The above captioned forms were previously approved on May 25, 2010 under SERFF Tracking Number CMBD-126621449. After receiving approval of the forms, we found that corrections would need to be made as follows:

1. The home office address was changed on all forms.
2. The definition of “Coinsurance” was added to Plan A.
3. All reference to Mental Illness was deleted because it would be covered under Medicare as any other illness.
4. The definition of “Medicare Eligible Expenses” was added to all plans.
3. The Basic Benefits language on Page 2 was amended on all plans.
4. The word “initial” was changed to “inpatient” under Medicare Part A Deductible on Page 3 of the Plan F and N.
6. Medicare Part B Deductible on Page 3 of Plan F was revised by adding the following language “…one hundred percent (100%) of…“.
7. The language “Every company must make available Plan A.” was changed to “Every company must make Plan A and either Plan C or F available” on the face page of the outline of coverage..
8. The High Deductible Plan F disclosure on the face page of the outline of coverage was corrected.
9. Plan N language in the Chart on Page 7 of the Outline of Coverage was corrected.

All changes have been highlighted. No other changes have been made.

The above captioned forms are enclosed for your consideration. Also attached are the following:

1. Flesch Certification
2. Variability Memorandum

The filing fee, in the amount of $450.00, has been submitted through EFT.
The policies are being filed to comply with the Genetic Information Nondiscrimination Act of 2008, the Medicare Improvements for Patients and Providers Act of 2008 and the National Association of Insurance Commissioners Minimum Standards Model Act. The policies will become effective on June 1, 2010. The form will sold by our agents in the field and also through direct response.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *CMBD-126734449* | *State:* | *Arkansas* |
| *Filing Company:* | *Combined Insurance Company of America* | *State Tracking Number:* | *46289* |
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| *Product Name:* | *Senior 2010 Medicare Supplement Policies- Plan A et al* | | |
| *Project Name/Number:* | *2010 Medicare Supplement Policies- Plan A et al/14910-AR-A ET AL* | | |

Application Form No.149276-AR, Outline of Coverage Form No. 014910 and Replacement Notice Form No. RN031020R are also attached.

The Actuarial Memorandum and rate sheets are attached.

Advertising will be filed once the forms are approved.

## Company and Contact

**Filing Contact Information**

| | |
|---|---|
| Sue Thill, Senior Policy Analyst | Sue.A.Thill@combined.com |
| 1000 Milwaukee Avenue | 847-953-1536 [Phone] |
| Glenview, IL 60025 | 847-953-1557 [FAX] |

**Filing Company Information**

| | | |
|---|---|---|
| Combined Insurance Company of America | CoCode: 62146 | State of Domicile: Illinois |
| 1000 Milwaukee Avenue | Group Code: 626 | Company Type: |
| Glenview, IL 60025 | Group Name: | State ID Number: |
| (847) 953-1531 ext. [Phone] | FEIN Number: 36-2136262 | |

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## Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $450.00 |
| Retaliatory? | No |
| Fee Explanation: | 3 POLICIES = $150 |
| | 3 RATES = 150 |
| | 1 APPLICATION = 50 |
| | 1 OUTLINE = 50 |
| | 1 NOTICE = 50 |
| | TOTAL =$450 |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| Combined Insurance Company of America | $450.00 | 07/22/2010 | 38211314 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *CMBD-126734449* | *State:* | *Arkansas* |
| *Filing Company:* | *Combined Insurance Company of America* | *State Tracking Number:* | *46289* |
| *Company Tracking Number:* | *14910-AR-A ET AL* | | |
| *TOI:* | *MS08I Individual Medicare Supplement - Standard Plans 2010* | *Sub-TOI:* | *MS08I.001 Plan A 2010* |
| *Product Name:* | *Senior 2010 Medicare Supplement Policies- Plan A et al* | | |
| *Project Name/Number:* | *2010 Medicare Supplement Policies- Plan A et al/14910-AR-A ET AL* | | |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Stephanie Fowler | 08/03/2010 | 08/03/2010 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *CMBD-126734449* | *State:* | *Arkansas* |
| *Filing Company:* | *Combined Insurance Company of America* | *State Tracking Number:* | *46289* |
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| *TOI:* | *MS08I Individual Medicare Supplement - Standard Plans 2010* | *Sub-TOI:* | *MS08I.001 Plan A 2010* |
| *Product Name:* | *Senior 2010 Medicare Supplement Policies- Plan A et al* | | |
| *Project Name/Number:* | *2010 Medicare Supplement Policies- Plan A et al/14910-AR-A ET AL* | | |

# Disposition

Disposition Date: 08/03/2010
Implementation Date:
Status: Approved-Closed
Comment: This approval is subject to the following:

• Increases will not be given more frequently than once in a twelve-month period;

• Both the insured and agent shall be notified by the insurer of its intention to increase the rate for renewal not less than thirty (30) days prior to the effective date of the renewal.

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *CMBD-126734449* | *State:* | *Arkansas* |
| *Filing Company:* | *Combined Insurance Company of America* | *State Tracking Number:* | *46289* |
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| *Product Name:* | *Senior 2010 Medicare Supplement Policies- Plan A et al* | | |
| *Project Name/Number:* | *2010 Medicare Supplement Policies- Plan A et al/14910-AR-A ET AL* | | |

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | Approved | Yes |
| **Supporting Document** | Application | Approved | Yes |
| **Supporting Document** | Health - Actuarial Justification | Approved | No |
| **Supporting Document** | Outline of Coverage | Approved | Yes |
| **Supporting Document** | VARIABILITY MEMORANDUM | Approved | Yes |
| **Supporting Document** | REVISED FORMS WITH HIGHLIGHTED CHANGES | Approved | Yes |
| **Form** | MEDICARE SUPPLEMENT POLICY - PLAN A | Approved | Yes |
| **Form** | MEDICARE SUPPLEMENT POLICY - PLAN F | Approved | Yes |
| **Form** | MEDICARE SUPPLMENT POLICY - PLAN N | Approved | Yes |
| **Form** | REPLACEMENT NOTICE | Approved | Yes |
| **Rate** | RATE SHEET | Approved | Yes |
| **Rate** | RATE SHEET | Approved | Yes |
| **Rate** | RATE SHEET | Approved | Yes |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *CMBD-126734449* | *State:* | *Arkansas* |
| *Filing Company:* | *Combined Insurance Company of America* | *State Tracking Number:* | *46289* |
| *Company Tracking Number:* | *14910-AR-A ET AL* | | |
| *TOI:* | *MS08I Individual Medicare Supplement - Standard Plans 2010* | *Sub-TOI:* | *MS08I.001 Plan A 2010* |
| *Product Name:* | *Senior 2010 Medicare Supplement Policies- Plan A et al* | | |
| *Project Name/Number:* | *2010 Medicare Supplement Policies- Plan A et al/14910-AR-A ET AL* | | |

# Form Schedule

**Lead Form Number: 14910-AR-A ET AL**

| Schedule Item Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Approved 08/03/2010 | 14910-AR-A | Policy/Contract/Fraternal Certificate | MEDICARE SUPPLEMENT POLICY - PLAN A | Initial | | 50.000 | 14910-AR-A.pdf |
| Approved 08/03/2010 | 14911-AR-F | Policy/Contract/Fraternal Certificate | MEDICARE SUPPLEMENT POLICY - PLAN F | Initial | | 50.000 | 14911-AR-F.pdf |
| Approved 08/03/2010 | 14912-AR-N | Policy/Contract/Fraternal Certificate | MEDICARE SUPPLMENT POLICY - PLAN N | Initial | | 50.000 | 14912-AR-N.pdf |
| Approved 08/03/2010 | RN031020R | Other | REPLACEMENT NOTICE | Initial | | | RN031020R.pdf |

# MEDICARE SUPPLEMENT POLICY - PLAN A


**Combined Insurance Company of America**
**A Legal Reserve Stock Corporation**
**(herein called Combined)**
**[Home Office and Policyholder Service Center**
**111 East Wacker Drive • Suite 700 • Chicago, Illinois 60601]**
**[1-800-544-5531]**

## IMPORTANT NOTICE

Please read the copy of the application attached to this policy. Carefully check the application and write to the company, Combined Insurance Company of America, [5050 Broadway, Chicago, Illinois 60640], within 10 days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the policy and the policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

## GUIDE TO POLICY PROVISIONS



NOTICE TO BUYER: THE POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

Combined agrees to pay you, the Insured named in the Schedule, the benefits of this policy and any riders attached to it, subject to all the terms and limitations of this policy and any riders. This policy is issued in consideration of the statements made in the application and the payment of the initial premium.

## 30 DAY RIGHT TO EXAMINE POLICY

**Please read this policy. If you are not satisfied with this policy for any reason, return it to Combined's Home Office or the agent who sold it within 30 days of the date it is delivered. Any premium paid will be returned to you and this policy will be deemed void from the beginning.**

## GUARANTEED RENEWABLE

Combined guarantees that it will renew this policy for your lifetime. It will continue in force so long as the premium then in effect is paid on or before the due date or within the grace period. Combined reserves the right to change the premium. Any change in premium must be made on all policies of the same class.

Cost sharing amounts under Medicare will be changed automatically to coincide with any applicable changes in the Medicare deductible and co-payment percentage factors. Combined has the right to adjust the premium to correspond with such changes.

Combined will notify you in writing of any premium change at least 30 days before the effective date of the change.

## DEFINITIONS

"Benefit Period" means a period starting on the first day of covered Hospital confinement, and ending on the 60th consecutive day you are not confined in a Hospital (as defined by Medicare).

"Calendar Year" means the period from January 1st through December 31st.

"Coinsurance" means that part that you have to pay of the posthospital Skilled Nursing Facility Care expenses recognized as reasonable by Medicare.

"Doctor" means a licensed practitioner of the healing arts as defined by Medicare, acting within the scope of his or her license.

"Hospital" means an institution which is defined as such by Medicare. It does not include any facility not covered by Medicare.

"Injury" means a bodily injury due to an accident.

"Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

**"**Medicare Eligible Expenses" are expenses of the kinds covered by Medicare Parts A and B. They must be recognized as reasonable and medically necessary by Medicare.

"Sickness" means bodily illness or disease diagnosed or treated by a Doctor after the Effective Date.

## BASIC BENEFITS

**Medicare Parts A and B**

Combined will pay you during any benefit period for an Injury or Sickness which requires you to be Hospital confined for a Medicare approved treatment while this policy is in force.

In each Calendar Year, Combined will pay you Part B Eligible Expenses for Medicare approved treatment of a covered Injury or Sickness.

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
6. Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

## EXCLUSIONS

Benefits will not be paid for: (a) services rendered by or covered by any agency of a State government (except Medicaid) when you have no obligation to pay for such services; or (b) expenses covered and payable under Medicare.

## UNIFORM PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between the Insured and Combined. No change in this policy will be effective until approved by an executive officer of Combined. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** Misstatements in the Application: After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred after the expiration of such 2 year period.

**GRACE PERIOD:** This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force.

**REINSTATEMENT:** If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by Combined (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If Combined or its agent requires an application for reinstatement and the application is approved, the policy will be reinstated as of the approval date.

The reinstated policy will cover only such hospitalization or treatment that starts after the date of reinstatement. In all other respects the rights of the Insured and Combined will remain the same.

**NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Combined at [P.O. Box 638, Bellingham, Washington 98227-0638] or to Combined's agent. Combined will accept notice from a Medicare Part B carrier on claims submitted on the Insured's behalf by physicians and suppliers or the Explanation of Medicare Benefits (EOMB). Notice should include the name of the Insured and the policy number.

**CLAIM FORMS:** When Combined receives the notice of claim, it will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of loss requirements by giving Combined a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

**PROOFS OF LOSS:** If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Combined within 90 days after the end of each period for which Combined is liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, Combined shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless the claimant was legally incapacitated.

**TIME OF PAYMENT OF CLAIMS:** After receiving written proof of loss, Combined will pay immediately all benefits then due.

**PAYMENT OF CLAIMS:** Benefits will be paid to the Insured. Any benefits unpaid at death will be paid to the deceased's Insured's estate.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** Combined at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

**LEGAL ACTIONS:** No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after 3 years from the time written proof of loss is required to be given.

**MISSTATEMENT OF AGE:** If your age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.

**CONFORMITY WITH STATE STATUTES:** Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which the Insured resides on that date is amended to conform to the minimum requirements of such laws.

## GENERAL PROVISIONS

**EFFECTIVE DATE:** This policy takes effect and terminates at 12:01 A.M., Standard Time, at the place where you reside. It is effective on the Effective Date shown on the Schedule. Premium due dates, policy anniversaries and policy years shall be computed from the Effective Date.

**EXTENSION OF BENEFITS:** Termination of the policy shall be without prejudice to a continuous loss which commenced while this policy was in force, but the extension of benefits is conditioned upon the continuous total disability of the Insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

**REFUND OF UNEARNED PREMIUM:** Upon your death any proceeds payable will include a refund of premium paid for this policy for any period beyond the end of the policy month in which death occurred.

**MEDICAID ENTITLEMENT AFTER POLICY EFFECTIVE DATE:** If you apply for and are determined to be eligible for benefits under Title XIX of the Social Security Act ("Medicaid"), you may have the benefits and premiums under this policy suspended while you are so eligible, for up to twenty-four (24) months. You must notify Combined within 90 days after you become so eligible for Medicaid.

If you suspend the benefits and premiums as described above and then lose entitlement to Medicaid, this policy will be reinstituted, effective on the date of Medicaid termination if: (1) you notify Combined within 90 days of such loss of assistance; and (2) pay the required premium. The premium and coverage will be as favorable as if the policy was not suspended. There will be no waiting period for pre-existing conditions.

In Witness Whereof, Combined has caused this policy to be signed by our Chairman and Secretary.
[

Chairman and
Chief Executive Officer]

Secretary

## SCHEDULE

Insured: _____ Effective Date: _____

Policy Form Number: _____ Initial Premium $ _____

Policy Number: _____ Plan _____

## ELIGIBILITY

Eligible persons are those eligible for Medicare and who are insurable in accordance with Combined's underwriting standards. However, if the eligible person is enrolled in Medicare Part B, is age 65 and applies for this policy within 6 months from his or her 65th birthdate, issuance of this policy is guaranteed. Policy issuance is also guaranteed if the person is over age 65 and applies for this coverage within the first [6] months of Medicare Part B enrollment.

## MEDICARE SUPPLEMENT POLICY

# MEDICARE SUPPLEMENT POLICY - PLAN F


**Combined Insurance Company of America**
**A Legal Reserve Stock Corporation**
**(herein called Combined)**
**[Home Office and Policyholder Service Center**
**111 East Wacker Drive • Suite 700 • Chicago, Illinois 60601]**
**[1-800-544-5531]**

## IMPORTANT NOTICE

Please read the copy of the application attached to this policy. Carefully check the application and write to the company, Combined Insurance Company of America, [5050 Broadway, Chicago, Illinois 60640], within 10 days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the policy and the policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

## GUIDE TO POLICY PROVISIONS



NOTICE TO BUYER: THE POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

Combined agrees to pay you, the Insured named in the Schedule, the benefits of this policy and any riders attached to it, subject to all the terms and limitations of this policy and any riders. This policy is issued in consideration of the statements made in the application and the payment of the initial premium.

## 30 DAY RIGHT TO EXAMINE POLICY

**Please read this policy. If you are not satisfied with this policy for any reason, return it to Combined's Home Office or the agent who sold it within 30 days of the date it is delivered. Any premium paid will be returned to you and this policy will be deemed void from the beginning.**

## GUARANTEED RENEWABLE

Combined guarantees that it will renew this policy for your lifetime. It will continue in force so long as the premium then in effect is paid on or before the due date or within the grace period. Combined reserves the right to change the premium. Any change in premium must be made on all policies of the same class.

Cost sharing amounts under Medicare will be changed automatically to coincide with any applicable changes in the Medicare deductible and co-payment percentage factors. Combined has the right to adjust the premium to correspond with such changes.

Combined will notify you in writing of any premium change at least 30 days before the effective date of the change.

Form No. 14911-AR-F

## DEFINITIONS

"Benefit Period" means a period starting on the first day of covered Hospital confinement, and ending on the 60th consecutive day you are not confined in a Hospital (as defined by Medicare).

"Calendar Year" means the period from January 1st through December 31st.

"Coinsurance" means that part that you have to pay of the posthospital Skilled Nursing Facility Care expenses recognized as reasonable by Medicare.

"Doctor" means a licensed practitioner of the healing arts as defined by Medicare, acting within the scope of his or her license.

"Hospital" means an institution which is defined as such by Medicare. It does not include any facility not covered by Medicare.

"Injury" means a bodily injury due to an accident.

"Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

**"**Medicare Eligible Expenses" are expenses of the kinds covered by Medicare Parts A and B. They must be recognized as reasonable and medically necessary by Medicare.

"Sickness" means bodily illness or disease diagnosed or treated by a Doctor after the Effective Date.

## BASIC BENEFITS

**Medicare Parts A and B**

Combined will pay you during any benefit period for an Injury or Sickness which requires you to be Hospital confined for a Medicare approved treatment while this policy is in force.

In each Calendar Year, Combined will pay you Part B Eligible Expenses for Medicare approved treatment of a covered Injury or Sickness.

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B Deductible.
6. Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

## ADDITIONAL BENEFITS

**Medicare Part A Deductible**

When a covered Injury or Sickness requires you to be Hospital confined for Medicare approved treatment while the policy is in force, Combined will pay one hundred percent (100%), during any one Benefit Period, the cost you incur for the Medicare Part A inpatient Hospital deductible.

**Skilled Nursing Facility Care**

When a covered Injury or Sickness requires you to be confined in a Skilled Nursing Facility for skilled nursing care, Combined will pay the Medicare posthospital Skilled Nursing Facility Care actual billed charges up to the co-insurance amount for the 21st day to the 100th covered day of such confinement. The confinement must begin within 30 days of a covered Hospital confinement of at least three (3) consecutive days. Your Doctor must recommend and you must receive the care for the further treatment of the same or related Injury or Sickness for which you were hospitalized.

"Skilled Nursing Facility" is a facility that provides Skilled Nursing Care and: (a) is approved by Medicare for payment of Medicare Part A benefits; or (b) is qualified to receive such Medicare approval, if requested.

"Skilled Nursing Care" is care that is or would be recognized as Skilled Nursing Care under Medicare Part A based on the Medicare criteria in force at the time the care is received.

**Medicare Part B Deductible**

In each Calendar Year during which you incur Medicare Part B Eligible Expenses for the Medicare approved treatment of a covered Injury or Sickness and the treatment occurs while the policy is in force, Combined will pay one hundred percent (100%) of the cost you incur for the Medicare Part B deductible.

**Medicare Part B Excess Charges**

In each Calendar Year during which you incur Medicare Part B Eligible Expenses for the Medicare approved treatment of a covered Injury or Sickness and the treatment occurs while the policy is in force, Combined will pay one hundred percent (100%) of the difference between the Medicare Part B Eligible Expenses and the amount charged by the doctor which can be no greater than the limiting charge allowed by Medicare.

**Medically Necessary Emergency Care In a Foreign Country**

To the extent not covered by Medicare, Combined will pay eighty percent (80%) of billed charges for Medicare Eligible Expenses for medically necessary emergency Hospital, Doctor and medical care received in a foreign country, if: (1) the care would have been covered by Medicare if provided in the United States; and (2) the care began during the first sixty (60) consecutive days of each trip outside the United States.

This benefit is subject to: (1) a two hundred fifty dollar ($250) Calendar Year deductible; and (2) a lifetime maximum benefit of fifty thousand dollars ($50,000).

For purposes of this section, "Emergency Care" means care needed immediately because of an Injury or Sickness of sudden and unexpected onset.

## EXCLUSIONS

Benefits will not be paid for: (a) services rendered by or covered by any agency of a State government (except Medicaid) when you have no obligation to pay for such services; or (b) expenses covered and payable under Medicare.

## UNIFORM PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between the Insured and Combined. No change in this policy will be effective until approved by an executive officer of Combined. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** Misstatements in the Application: After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred after the expiration of such 2 year period.

**GRACE PERIOD:** This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force.

**REINSTATEMENT:** If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by Combined (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If Combined or its agent requires an application for reinstatement and the application is approved, the policy will be reinstated as of the approval date.

The reinstated policy will cover only such hospitalization or treatment that starts after the date of reinstatement. In all other respects the rights of the Insured and Combined will remain the same.

**NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Combined at [P.O. Box 638, Bellingham, Washington 98227-0638] or to Combined's agent. Combined will accept notice from a Medicare Part B carrier on claims submitted on the Insured's behalf by physicians and suppliers or the Explanation of Medicare Benefits (EOMB). Notice should include the name of the Insured and the policy number.

**CLAIM FORMS:** When Combined receives the notice of claim, it will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of loss requirements by giving Combined a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

**PROOFS OF LOSS:** If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Combined within 90 days after the end of each period for which Combined is liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, Combined shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless the claimant was legally incapacitated.

**TIME OF PAYMENT OF CLAIMS:** After receiving written proof of loss, Combined will pay immediately all benefits then due.

**PAYMENT OF CLAIMS:** Benefits will be paid to the Insured. Any benefits unpaid at death will be paid to the deceased's Insured's estate.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** Combined at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

**LEGAL ACTIONS:** No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after 3 years from the time written proof of loss is required to be given.

**MISSTATEMENT OF AGE:** If your age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.

**CONFORMITY WITH STATE STATUTES:** Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which the Insured resides on that date is amended to conform to the minimum requirements of such laws.

## GENERAL PROVISIONS

**EFFECTIVE DATE:** This policy takes effect and terminates at 12:01 A.M., Standard Time, at the place where you reside. It is effective on the Effective Date shown on the Schedule. Premium due dates, policy anniversaries and policy years shall be computed from the Effective Date.

**EXTENSION OF BENEFITS:** Termination of the policy shall be without prejudice to a continuous loss which commenced while this policy was in force, but the extension of benefits is conditioned upon the continuous total disability of the Insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

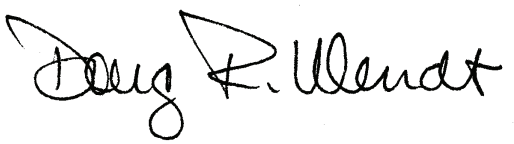
**REFUND OF UNEARNED PREMIUM:** Upon your death any proceeds payable will include a refund of premium paid for this policy for any period beyond the end of the policy month in which death occurred.

**MEDICAID ENTITLEMENT AFTER POLICY EFFECTIVE DATE:** If you apply for and are determined to be eligible for benefits under Title XIX of the Social Security Act ("Medicaid"), you may have the benefits and premiums under this policy suspended while you are so eligible, for up to twenty-four (24) months. You must notify Combined within 90 days after you become so eligible for Medicaid.

If you suspend the benefits and premiums as described above and then lose entitlement to Medicaid, this policy will be reinstituted, effective on the date of Medicaid termination if: (1) you notify Combined within 90 days of such loss of assistance; and (2) pay the required premium. The premium and coverage will be as favorable as if the policy was not suspended. There will be no waiting period for pre-existing conditions.

In Witness Whereof, Combined has caused this policy to be signed by our Chairman, President and Secretary.

[



Chairman and
Chief Executive Officer]

Secretary

## SCHEDULE

Insured: _____ Effective Date: _____

Policy Number: _____ Initial Premium: $ _____

Policy Form Number: _____ Plan: _____

## ELIGIBILITY

Eligible persons are those eligible for Medicare and who are insurable in accordance with Combined's underwriting standards. However, if the eligible person is enrolled in Medicare Part B, is age 65 and applies for this policy within 6 months from his or her 65th birthdate, issuance of this policy is guaranteed. Policy issuance is also guaranteed if the person is over age 65 and applies for this coverage within the first [6] months of Medicare Part B enrollment.

## MEDICARE SUPPLEMENT POLICY

# MEDICARE SUPPLEMENT POLICY - PLAN N


**Combined Insurance Company of America**
**A Legal Reserve Stock Corporation**
**(herein called Combined)**
**[Home Office and Policyholder Service Center**
**111 East Wacker Drive • Suite 700 • Chicago, Illinois 60601]**
**[1-800-544-5531]**

## IMPORTANT NOTICE

Please read the copy of the application attached to this policy. Carefully check the application and write to the company, Combined Insurance Company of America, [5050 Broadway, Chicago, Illinois 60640], within 10 days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the policy and the policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

## GUIDE TO POLICY PROVISIONS



NOTICE TO BUYER: THE POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

Combined agrees to pay you, the Insured named in the Schedule, the benefits of this policy and any riders attached to it, subject to all the terms and limitations of this policy and any riders. This policy is issued in consideration of the statements made in the application and the payment of the initial premium.

## 30 DAY RIGHT TO EXAMINE POLICY

**Please read this policy. If you are not satisfied with this policy for any reason, return it to Combined's Home Office or the agent who sold it within 30 days of the date it is delivered. Any premium paid will be returned to you and this policy will be deemed void from the beginning.**

## GUARANTEED RENEWABLE

Combined guarantees that it will renew this policy for your lifetime. It will continue in force so long as the premium then in effect is paid on or before the due date or within the grace period. Combined reserves the right to change the premium. Any change in premium must be made on all policies of the same class.

Cost sharing amounts under Medicare will be changed automatically to coincide with any applicable changes in the Medicare deductible and copayment percentage factors. Combined has the right to adjust the premium to correspond with such changes.

Combined will notify you in writing of any premium change at least 30 days before the effective date of the change.

## DEFINITIONS

"Benefit Period" means a period starting on the first day of covered Hospital confinement, and ending on the 60th consecutive day you are not confined in a Hospital (as defined by Medicare).

"Calendar Year" means the period from January 1st through December 31st.

"Coinsurance" means that part that you have to pay of the posthospital Skilled Nursing Facility Care expenses recognized as reasonable by Medicare.

"Doctor" means a licensed practitioner of the healing arts as defined by Medicare, acting within the scope of his or her license.

"Hospital" means an institution which is defined as such by Medicare. It does not include any facility not covered by Medicare.

"Injury" means a bodily injury due to an accident.

"Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

**"**Medicare Eligible Expenses" are expenses of the kinds covered by Medicare Parts A and B. They must be recognized as reasonable and medically necessary by Medicare.

"Sickness" means bodily illness or disease diagnosed or treated by a Doctor after the Effective Date.

## BASIC BENEFITS

**Medicare Parts A and B**

Combined will pay you during any benefit period for an Injury or Sickness which requires you to be Hospital confined for a Medicare approved treatment while this policy is in force.

In each Calendar Year, Combined will pay you Part B Eligible Expenses for Medicare approved treatment of a covered Injury or Sickness.

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B Deductible.
6. Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

In each Calendar Year during which you incur Medicare Part B Eligible Expenses for Medicare approved treatment of a covered Injury or Sickness and the treatment occurs while the policy is in force, Combined will pay: 1) 100% of the cost you incur for the first 3 pints of unreplaced blood; and 2) the Medicare Part B Eligible Expenses not payable by Medicare after the deductible has been satisfied or in the case of hospital outpatient department services paid under a prospective payment system, with copayment in the following amounts: a) the lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and b) the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, the copayment shall be waived if you are admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

## ADDITIONAL BENEFITS

**Medicare Part A Deductible**

When a covered Injury or Sickness requires you to be Hospital confined for Medicare approved treatment while the policy is in force, Combined will pay one hundred percent (100%), during any one Benefit Period, the cost you incur for the Medicare Part A inpatient Hospital deductible.

**Skilled Nursing Facility Care**

When a covered Injury or Sickness requires you to be confined in a Skilled Nursing Facility for skilled nursing care, Combined will pay the Medicare posthospital Skilled Nursing Facility Care actual billed charges up to the coinsurance amount for the 21st day to the 100th covered day of such confinement. The confinement must begin within 30 days of a covered Hospital confinement of at least three (3) consecutive days. Your Doctor must recommend and you must receive the care for the further treatment of the same or related Injury or Sickness for which you were hospitalized.

"Skilled Nursing Facility" is a facility that provides Skilled Nursing Care and: (a) is approved by Medicare for payment of Medicare Part A benefits; or (b) is qualified to receive such Medicare approval, if requested.

"Skilled Nursing Care" is care that is or would be recognized as Skilled Nursing Care under Medicare Part A based on the Medicare criteria in force at the time the care is received.

**Medically Necessary Emergency Care in a Foreign Country**

To the extent not covered by Medicare, Combined will pay eighty percent (80%) of billed charges for Medicare Eligible Expenses for medically necessary emergency Hospital, Doctor and medical care received in a foreign country, if: (1) the care would have been covered by Medicare if provided in the United States; and (2) the care began during the first sixty (60) consecutive days of each trip outside the United States.

This benefit is subject to: (1) a two hundred fifty dollar ($250) Calendar Year deductible; and (2) a lifetime maximum benefit of fifty thousand dollars ($50,000).

For purposes of this section, "Emergency Care" means care needed immediately because of an Injury or Sickness of sudden and unexpected onset.

## EXCLUSIONS

Benefits will not be paid for: (a) services rendered by or covered by any agency of a State government (except Medicaid) when you have no obligation to pay for such services; or (b) expenses covered and payable under Medicare.

## UNIFORM PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between the Insured and Combined. No change in this policy will be effective until approved by an executive officer of Combined. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** Misstatements in the Application: After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred after the expiration of such 2 year period.

**GRACE PERIOD:** This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force.

**REINSTATEMENT:** If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by Combined (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If Combined or its agent requires an application for reinstatement and the application is approved, the policy will be reinstated as of the approval date.

The reinstated policy will cover only such hospitalization or treatment that starts after the date of reinstatement. In all other respects the rights of the Insured and Combined will remain the same.

**NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Combined at [P.O. Box 638, Bellingham, Washington 98227-0638] or to Combined's agent. Combined will accept notice from a Medicare Part B carrier on claims submitted on the Insured's behalf by physicians and suppliers or the Explanation of Medicare Benefits (EOMB). Notice should include the name of the Insured and the policy number.

**CLAIM FORMS:** When Combined receives the notice of claim, it will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of loss requirements by giving Combined a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

**PROOFS OF LOSS:** If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Combined within 90 days after the end of each period for which Combined is liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, Combined shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless the claimant was legally incapacitated.

**TIME OF PAYMENT OF CLAIMS:** After receiving written proof of loss, Combined will pay immediately all benefits then due.

**PAYMENT OF CLAIMS:** Benefits will be paid to the Insured. Any benefits unpaid at death will be paid to the deceased's Insured's estate.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** Combined at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

**LEGAL ACTIONS:** No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after 3 years from the time written proof of loss is required to be given.

**MISSTATEMENT OF AGE:** If your age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.

**CONFORMITY WITH STATE STATUTES:** Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which the Insured resides on that date is amended to conform to the minimum requirements of such laws.

## GENERAL PROVISIONS

**EFFECTIVE DATE:** This policy takes effect and terminates at 12:01 A.M., Standard Time, at the place where you reside. It is effective on the Effective Date shown on the Schedule. Premium due dates, policy anniversaries and policy years shall be computed from the Effective Date.

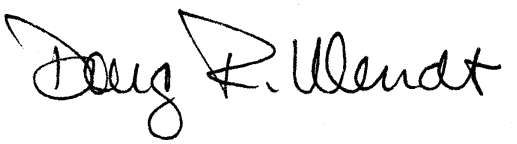
**EXTENSION OF BENEFITS:** Termination of the policy shall be without prejudice to a continuous loss which commenced while this policy was in force, but the extension of benefits is conditioned upon the continuous total disability of the Insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

**REFUND OF UNEARNED PREMIUM:** Upon your death any proceeds payable will include a refund of premium paid for this policy for any period beyond the end of the policy month in which death occurred.

**MEDICAID ENTITLEMENT AFTER POLICY EFFECTIVE DATE:** If you apply for and are determined to be eligible for benefits under Title XIX of the Social Security Act ("Medicaid"), you may have the benefits and premiums under this policy suspended while you are so eligible, for up to twenty-four (24) months. You must notify Combined within 90 days after you become so eligible for Medicaid.

If you suspend the benefits and premiums as described above and then lose entitlement to Medicaid, this policy will be reinstituted, effective on the date of Medicaid termination if: (1) you notify Combined within 90 days of such loss of assistance; and (2) pay the required premium. The premium and coverage will be as favorable as if the policy was not suspended. There will be no waiting period for pre-existing conditions.

In Witness Whereof, Combined has caused this policy to be signed by our Chairman and Secretary.
[



Chairman and
Chief Executive Officer]

Secretary

## SCHEDULE

Insured: _____ Effective Date: _____

Policy Form Number: _____ Initial Premium $ _____

Policy Number: _____ Plan _____

## ELIGIBILITY

Eligible persons are those eligible for Medicare and who are insurable in accordance with Combined's underwriting standards. However, if the eligible person is enrolled in Medicare Part B, is age 65 and applies for this policy within 6 months from his or her 65th birthdate, issuance of this policy is guaranteed. Policy issuance is also guaranteed if the person is over age 65 and applies for this coverage within the first [6] months of Medicare Part B enrollment.

## MEDICARE SUPPLEMENT POLICY

**COMBINED INSURANCE COMPANY OF AMERICA**
[111 East Wacker Drive • Suite 700 • Chicago, Illinois 60601]

## NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.**

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Combined Insurance Company of America. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT (BROKER OR OTHER REPRESENTATIVE):

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage Plan. The replacement policy is being purchased for the following reason (check one):

___ Additional benefits.
___ No change in benefits, but lower premiums.
___ Fewer benefits and lower premiums.
___ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
___ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

___ Other, (Please specify)_____

_____

_____

State law provides that your replacement policy or certificate may not contain new waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____ _____
(Signature of Agent, Broker or Other Representative) (Applicant's Signature)

_____ _____
Date

_____
(Typed Name and Address of Issuer, Agent, or Broker)

Form No. RN031020R **WHITE – HOME OFFICE COPY** **YELLOW – APPLICANT'S COPY**

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *CMBD-126734449* | *State:* | *Arkansas* |
| *Filing Company:* | *Combined Insurance Company of America* | *State Tracking Number:* | *46289* |
| *Company Tracking Number:* | *14910-AR-A ET AL* | | |
| *TOI:* | *MS08I Individual Medicare Supplement - Standard Plans 2010* | *Sub-TOI:* | *MS08I.001 Plan A 2010* |
| *Product Name:* | *Senior 2010 Medicare Supplement Policies- Plan A et al* | | |
| *Project Name/Number:* | *2010 Medicare Supplement Policies- Plan A et al/14910-AR-A ET AL* | | |

# Rate/Rule Schedule

| Schedule Item Status: | Document Name: | Affected Form Numbers: (Separated with commas) | Rate Action:* | Rate Action Information: | Attachments |
|---|---|---|---|---|---|
| Approved 08/03/2010 | RATE SHEET | 14910-AR-A | New | | AR Plan A RATE SHEET.pdf |
| Approved 08/03/2010 | RATE SHEET | 14911-AR-F | New | | AR Plan F RATE SHEET.pdf |
| Approved 08/03/2010 | RATE SHEET | 14912-AR-N | New | | AR Plan N RATE SHEET.pdf |

COMBINED INSURANCE COMPANY OF AMERICA
CHICAGO, ILLINOIS
NAIC COMPANY CODE #62146

**MEDICARE SUPPLEMENT**
**FOR THE STATE OF ARKANSAS**

**POLICY FORM 14910**
**Plan A**
**Standard Rates**

| | ***Annual Premium*** **All Zip Codes** **Non-Tobacco** | ***Annual Premium*** **All Zip Codes** **Tobacco** |
|---|---|---|
| 65 and up | $1,325.68 | $1,531.80 |

## Modal Factors:

| | |
|---|---|
| Semi-Annual: | 0.52 |
| PAC Monthly: | 0.09 |

Rate Sheet # 7020-AR

COMBINED INSURANCE COMPANY OF AMERICA
CHICAGO, ILLINOIS
NAIC COMPANY CODE #62146

**MEDICARE SUPPLEMENT**
**FOR THE STATE OF ARKANSAS**

**POLICY FORM 14911**
**Plan F**
**Standard Rates**

| | ***Annual Premium*** **All Zip Codes** **Non-Tobacco** | ***Annual Premium*** **All Zip Codes** **Tobacco** |
|---|---|---|
| 65 and up | $1,922.03 | $2,220.86 |

## Modal Factors:

| | |
|---|---|
| Semi-Annual: | 0.52 |
| PAC Monthly: | 0.09 |

Rate Sheet # 7021-AR

COMBINED INSURANCE COMPANY OF AMERICA
CHICAGO, ILLINOIS
NAIC COMPANY CODE #62146

**MEDICARE SUPPLEMENT**
**FOR THE STATE OF ARKANSAS**

**POLICY FORM 14912**
**Plan N**
**Standard Rates**

| | ***Annual Premium*** **All Zip Codes** **Non-Tobacco** | ***Annual Premium*** **All Zip Codes** **Tobacco** |
|---|---|---|
| 65 and up | $1,345.43 | $1,554.61 |

## Modal Factors:

| | |
|---|---|
| Semi-Annual: | 0.52 |
| PAC Monthly: | 0.09 |

Rate Sheet # 7022-AR

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *CMBD-126734449* | *State:* | *Arkansas* |
| *Filing Company:* | *Combined Insurance Company of America* | *State Tracking Number:* | *46289* |
| *Company Tracking Number:* | *14910-AR-A ET AL* | | |
| *TOI:* | *MS08I Individual Medicare Supplement - Standard Plans 2010* | *Sub-TOI:* | *MS08I.001 Plan A 2010* |
| *Product Name:* | *Senior 2010 Medicare Supplement Policies- Plan A et al* | | |
| *Project Name/Number:* | *2010 Medicare Supplement Policies- Plan A et al/14910-AR-A ET AL* | | |

# Supporting Document Schedules

**Item Status:** **Status Date:**

**Satisfied - Item:** Flesch Certification — Approved — 08/03/2010

**Comments:**

**Attachment:**

Readability Certification.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Application — Approved — 08/03/2010

**Comments:**

**Attachment:**

149276-AR.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** Outline of Coverage — Approved — 08/03/2010

**Comments:**

**Attachment:**

014910.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** VARIABILITY MEMORANDUM — Approved — 08/03/2010

**Comments:**

**Attachment:**

VARIABILITY MEMORANDUM.pdf

**Item Status:** **Status Date:**

**Satisfied - Item:** REVISED FORMS WITH — Approved — 08/03/2010

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *CMBD-126734449* | *State:* | *Arkansas* |
| *Filing Company:* | *Combined Insurance Company of America* | *State Tracking Number:* | *46289* |
| *Company Tracking Number:* | *14910-AR-A ET AL* | | |
| *TOI:* | *MS08I Individual Medicare Supplement - Standard Plans 2010* | *Sub-TOI:* | *MS08I.001 Plan A 2010* |
| *Product Name:* | *Senior 2010 Medicare Supplement Policies- Plan A et al* | | |
| *Project Name/Number:* | *2010 Medicare Supplement Policies- Plan A et al/14910-AR-A ET AL* | | |

HIGHLIGHTED CHANGES

**Comments:**

**Attachments:**

14910-AR-A  HIGHLIGHTED.pdf
14911-AR-F HIGHLIGHTED.pdf
14912-AR-N HIGHLIGHTED.pdf
149276-AR HIGHLIGHTED.pdf
014910 HIGHLIGHTED.pdf
RN031020R HIGHLIGHTED.pdf

COMBINED INSURANCE®
Combined Insurance Company of America

**READABILITY CERTIFICATION**

Form No. 14910-AR-A - Medicare Supplement Policy (Plan A)
14911-AR-F - Medicare Supplement Policy (Plan F)
14912-AR-N - Medicare Supplement Policy (Plan N)

The above captioned form(s) has a Flesch Index Score of 50 and meet(s) the minimum reading ease requirements.

Michael J. Hollar

Michael J. Hollar, Assistant Secretary

*Michael J. Hollar – Assistant Secretary - Product Filings/Government Relations/Law*
*Telephone: (847) 953-1531 Fax: (847) 953-1557 Toll Free: 888-449-3623 E-mail: michael.hollar@combined.com*

1000 N. Milwaukee Avenue • Glenview, Illinois 60025 • www.combinedinsurance.com
The ACE Group of Companies

COMBINED INSURANCE COMPANY OF AMERICA
("Combined") [111 East Wacker Drive, Suite 700, Chicago, IL 60601]
I apply to Combined for a policy to be issued on the basis of the statement below:

[ 6001149276 ]

APPLICATION NUMBER [ 6 0 0 1 ]

## APPLICANT'S PERSONAL INFORMATION

LANGUAGE PREFERENCE X E X S X F

M F INSURED'S FIRST NAME | MIDDLE INITIAL | LAST NAME

X X

INSURED'S RESIDENCE ADDRESS | RESIDENCE PHONE NUMBER

CITY | STATE | ZIP

INSURED'S DATE OF BIRTH (M M D D Y Y Y Y) | INSURED'S AGE | CALL TYPE ADDRESS: X Home X Business

INSURED'S BILLING ADDRESS IF DIFFERENT FROM RESIDENCE

CITY | STATE | ZIP

## PLAN SELECTION

**PLAN APPLYING FOR:** [ A X (14910) F X (14911) N X (14912) ]

**Do you have another Policy with Combined?** X YES X NO

REFERENCE CICA POLICY

INSURED'S HEIGHT | INSURED'S WEIGHT

RATE CLASS

PLEASE INDICATE YOUR HEIGHT AND WEIGHT: FT. IN. LBS.

Preferred X
Standard Non-Tobacco X
Standard Tobacco X

PREMIUM COLLECTED
$ .
(based on age on effective date)

PREMIUM MODE
Monthly APC X Semi-Annual X Annual X
Credit Card X

REQUESTED EFFECTIVE DATE (M M D D Y Y Y Y)

**If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.**

TO THE BEST OF MY KNOWLEDGE AND BELIEF: **(PLEASE ANSWER ALL QUESTIONS.)**

A. Did you turn age 65 in the last 6 months? X YES X NO

B. Did you or will you enroll in Medicare Part B within [6] months before or after the Date of Application? X YES X NO

C. Please indicate effective date of Medicare Part B: (M M D D Y Y Y Y) Medicare #
(Number on Medicare Card or Social Security Number)

D. 1. Do you have another Medicare Supplement policy in force? X YES X NO

2. Do you intend to replace your current Medicare supplement policy with this policy? X YES X NO
***(If "Yes" complete Replacement Form.)***

E. 1. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) X YES X NO

2. If so, what are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)

START (M M D D Y Y Y Y) END (M M D D Y Y Y Y)

F. If the answer to Question D or E is "YES", complete the following:

| Company Name and Address | Type of Policy | Policy Number |
|---|---|---|
| | | |

**If you are applying under Open Enrollment or Guarantee Issue, please advance to Page 3 upon completion of above questions.**

**IF QUESTIONS A OR B ARE ANSWERED "YES", YOU DO NOT HAVE TO ANSWER HEALTH QUESTIONS G THROUGH J.**
**Please complete if applying during a Non-Open Enrollment or Non-Guarantee Issue Period.**

G. **Have you used any form of tobacco in the last 12 months?** YES NO

**IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED "YES", THE APPLICANT IS UNINSURABLE.**

H. HAVE YOU RECEIVED ANY MEDICAL ADVICE INCLUDING REFERRALS FROM ANOTHER PHYSICIAN FOR DIAGNOSTIC TESTS OR SURGERY FROM A MEMBER OF THE MEDICAL PROFESSION OR TAKEN ANY MEDICATION IN THE PAST TWO YEARS FOR:

1. Stroke, TIA (Mini Stroke), Heart Attack, Congestive Heart Failure, Chronic Atrial Fibrillation or Coronary Artery Disease? YES NO
2. Cancer (excluding Skin Cancer), Leukemia, Hodgkins' Disease, Melanoma or any other type of Cancer? YES NO
3. Alzheimer's Disease, Dementia, Parkinson's Disease, Lou Gehrig's Disease/ALS, Multiple Sclerosis or Muscular Dystrophy? YES NO
4. Chronic Obstructive Pulmonary Disease, Chronic Bronchitis or Emphysema? YES NO
5. Manic Depression, Bipolar Disorder or Mental or Nervous Disorder requiring Psychiatric Care? YES NO
6. Alcoholism, Drug Addiction, Cirrhosis of the Liver, Kidney Failure or Insulin Dependent Diabetes? YES NO
7. Crippling or Debilitating Arthritis? YES NO
8. Oxygen Therapy, Kidney Dialysis, a Defibrillator, Pacemaker, Coronary Bypass Surgery, Angioplasty or Stent placement? YES NO
9. Diagnosis or treatment by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or tested positive for HIV? YES NO
10. Do you require or receive any assistance with any of your activities of daily living such as bathing, transferring, toileting, eating, dressing or continence? YES NO
11. Do you currently use any durable medical equipment such as a 4 prong cane, walker, wheelchair or motorized aid? YES NO

I. WITHIN THE PAST TWO (2) YEARS HAVE YOU HAD ANY MEDICAL ADVICE (INCLUDING REFERRALS TO OTHER PHYSICIANS FOR DIAGNOSTIC TESTS AND SURGERY) OR TREATMENT FROM A MEMBER OF THE MEDICAL PROFESSION OR TAKEN ANY PRESCRIPTION MEDICATION FOR ANY OTHER MEDICAL CONDITION(S) NOT LISTED ABOVE? YES NO

**(IF NO, PLEASE INCLUDE PRIMARY PHYSICIAN'S NAME, ADDRESS AND PHONE NUMBER)**

| MEDICAL CONDITION (If hospitalized, provide dates) | DATE OF DIAGNOSIS | TYPE OF TREATMENT if currently receiving treatment | PHYSICIAN NAME, ADDRESS (Street, City, State, Zip) AND PHONE NUMBER |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

J. PLEASE LIST ALL MEDICATIONS (PRESCRIPTION OR NON-PRESCRIPTION) YOU ARE CURRENTLY TAKING AND THE REASON FOR TAKING THEM IN THE SECTION BELOW:

| NAME OF MEDICATION | DOSAGE AND FREQUENCY PER DAY | MEDICAL CONDITION |
|---|---|---|
| | | |
| | | |
| | | |

**Please advance to Page 3 to complete questions K., L., M., and N.**

## OTHER COVERAGE INFORMATION

K. Are you covered for medical assistance through the state Medicaid program? X YES X NO
[NOTE TO APPLICANT: If you are participating in a "Spend-down Program" and have not met your "Share of Cost," please answer NO to this question]

If Yes,
(a) Will Medicaid pay your premiums for this Medicare supplement policy? X YES X NO

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? X YES X NO

L. Agents must list any other health insurance policies they have sold the applicant: (If None, state None)

1. List policies sold which are still in force. _____

2. List policies sold in the past five years which are no longer in force. _____

M. Are you applying for Guarantee Issue? ***(If "YES" please complete Question N and attach a copy of your termination notice, HIPAA certificate or other correspondence to validate your eligibility for open enrollment or guarantee issue.)*** X YES X NO

N. 1. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START M M D D Y Y Y Y END M M D D Y Y Y Y

2. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? X YES X NO

3. Was this your first time in this type of Medicare plan? X YES X NO

4. Did you drop a Medicare supplement policy to enroll in the Medicare plan? X YES X NO

---

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested within 90 days after losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

## AUTHORIZATION

To the best of my knowledge and belief, my answers are true and correct. I acknowledge receipt of the Outline of Coverage that describes the Policy for which I am applying, the pamphlet entitled, "Guide to Health Insurance for People with Medicare" and the Notice of Information Practices.

I authorize Combined Insurance Company of America or its reinsurers for the purpose of evaluating this application for insurance to acquire, review, research the release of information from the following: Medical Professional; Hospital; Physician; Medical Practitioner; Clinic; Pharmacy; Pharmacy Benefits Manager or other pharmacy-related services organization; Health Plan; other medical or medically-related facilities; Government Agency; Medical Information Bureau, Inc., (MIB); Consumer Reporting Agency; Combined's own records. Combined Insurance Company of America will acquire through a personal phone interview or another means from the above any needed information on the Insured, his/her dependents including but not limited to copies of records, concerning advice, care or treatment, on past or present health, the use of drugs or alcohol, and information relating to mental illness. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any doctor, the Medical Information Bureau, Inc. or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization will remain valid for a period of two years from the application date of the policy. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to you or your representative upon request to Combined.

You may revoke this authorization at any time by writing Combined; however, such revocation may affect coverage.

Failure to sign this authorization may impair the ability of Combined to evaluate or process this application and may be a basis for denying this application.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

An Authorized Interviewer may call to obtain additional information required to complete this application. Check most convenient time to call and provide telephone number(s) where you can be reached:

X Primary Phone Number (  ) _____ X Secondary Phone Number (  ) _____

X 6:30 am - 8:00 am X 8:00 am - 12:00 pm X 12:00 pm - 3:00 pm X 3:00 pm - 6:00 pm X After 6:00 pm

---

X _____ Date of Application: M M D D Y Y Y Y

Signature of Insured

City (where signed): _____ State: _____

[ _____ _____ Date: M M D D Y Y Y Y ]

Agent's/Producer's Signature Agent Code

Primary Agent/Producer contact information

| |
|---|
| Agent's/Producer's phone |
| Agent's/Producer's e-mail address |
| Agent's/Producer's cell phone |

Home Office use only

| Complete this area when splitting commissions. | |
|---|---|
| Primary | Secondary |
| Agent/Producer Name | Agent/Producer Name |
| Code # | Code # |
| Percentage | Percentage |
| Agent's/Producer's Signature | Agent's/Producer's Signature |

[ 6005149276 ]

APPLICATION NUMBER [ 6 0 0 5 ]

**AUTOMATIC PREMIUM COLLECTION**
**(Automatic Premium for Monthly Mode ONLY)**

Name of Financial Institution: City: State:

BANK ROUTING NUMBER BANK ACCOUNT NUMBER

**Complete if adding policies from another application**

NAME OF PAYOR APPEARING ON BANK/FINANCIAL INSTITUTION

Charge my Checking X Savings X Initial Premium Collected $ **Policy Type** (L = Life, H = Health) →

Credit Card X Preferred Billing Date (1–28 only) Amount Charged

NAME OF CARDHOLDER CARDHOLDER ZIP CODE

ACCOUNT NUMBER EXPIRES MONTH YEAR CARD TYPE VISA X MC X

**AUTHORIZATION FOR ELECTRONIC DEBIT**

I hereby authorize Combined Insurance Company ("Combined"), to initiate electronic debit entries or effect a change by any other commercially accepted method, to my checking or savings account indicated above in the financial institution named above, hereinafter called Depository, to debit the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification from me of its termination in such time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it.

I understand that if any listed policy contains a premium and benefit increase provision, future premiums will increase as indicated in the policy Premium and Benefit schedule.

I agree that if premiums are not paid within the grace period under the subject policy(ies), as in the event withdrawals are dishonored, the policy(ies) will terminate. Life policies may have non-forfeiture benefits.

PAYOR'S PHONE NUMBER

X Date: M M D D Y Y Y Y

Signature of Payor (Signature must be the same as on file at the bank/financial institution)

| Application No. | |
|---|---|

| Amount of Insurance | $ |
|---|---|

**COMBINED INSURANCE COMPANY OF AMERICA • [111 East Wacker Drive • Suite 700 • Chicago, IL 60601]**

## MEDICARE SUPPLEMENT INSURANCE APPLICATION RECEIPT

I have applied for an insurance policy from Combined Insurance Company of America (Combined). With my application I have submitted a check, money order or cash in the amount of $_____. This receipt shall be void and no coverage applied for will not take affect if any check, draft or money order given in payment of the first premium is not honored.

I understand that this payment will be held by Combined and, if my application is approved and a policy is issued to me, Combined will accept this payment and apply it as the premium for the first period of coverage under the policy.

I understand that this policy will **NOT** become effective unless my application is approved in writing by Combined and a policy is delivered to me. I understand that if Combined approves my application, I will have coverage beginning on the date of such approval by Combined. If my application is not approved by Combined, the above premium will be refunded to me within 60 days of denial. I understand that in no event will I have coverage for the period between today and the date on which Combined approves or disapproves my application.

Proposed Insured's Signature: _____ Date: _____

Agent's Signature: _____ Agent Code: _____ Date: _____

Form No. 149276-Receipt

Home Office Copy
(remains with application)

[ 6005149276 ]

APPLICATION NUMBER [ 6 0 0 5 ]

## AUTOMATIC PREMIUM COLLECTION
**(Automatic Premium for Monthly Mode ONLY)**

Name of Financial Institution: City: State:

BANK ROUTING NUMBER BANK ACCOUNT NUMBER

**Complete if adding policies from another application**

NAME OF PAYOR APPEARING ON BANK/FINANCIAL INSTITUTION

Charge my Checking X Savings X Initial Premium Collected $ **Policy Type** (L = Life, H = Health) →

Credit Card X Preferred Billing Date (1–28 only) Amount Charged

NAME OF CARDHOLDER CARDHOLDER ZIP CODE

ACCOUNT NUMBER EXPIRES MONTH YEAR CARD TYPE VISA X MC X

### AUTHORIZATION FOR ELECTRONIC DEBIT

I hereby authorize Combined Insurance Company ("Combined"), to initiate electronic debit entries or effect a change by any other commercially accepted method, to my checking or savings account indicated above in the financial institution named above, hereinafter called Depository, to debit the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification from me of its termination in such time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it.

I understand that if any listed policy contains a premium and benefit increase provision, future premiums will increase as indicated in the policy Premium and Benefit schedule.

I agree that if premiums are not paid within the grace period under the subject policy(ies), as in the event withdrawals are dishonored, the policy(ies) will terminate. Life policies may have non-forfeiture benefits.

PAYOR'S PHONE NUMBER

X Date: M M D D Y Y Y Y

Signature of Payor (Signature must be the same as on file at the bank/financial institution)

| Application No. | | Amount of Insurance | $ |
|---|---|---|---|

## COMBINED INSURANCE COMPANY OF AMERICA • [111 East Wacker Drive • Suite 700 • Chicago, IL 60601]

## MEDICARE SUPPLEMENT INSURANCE APPLICATION RECEIPT

I have applied for an insurance policy from Combined Insurance Company of America (Combined). With my application I have submitted a check, money order or cash in the amount of $_____. This receipt shall be void and no coverage applied for will not take affect if any check, draft or money order given in payment of the first premium is not honored.

I understand that this payment will be held by Combined and, if my application is approved and a policy is issued to me, Combined will accept this payment and apply it as the premium for the first period of coverage under the policy.

I understand that this policy will **NOT** become effective unless my application is approved in writing by Combined and a policy is delivered to me. I understand that if Combined approves my application, I will have coverage beginning on the date of such approval by Combined. If my application is not approved by Combined, the above premium will be refunded to me within 60 days of denial. I understand that in no event will I have coverage for the period between today and the date on which Combined approves or disapproves my application.

Proposed Insured's Signature: _____ Date: _____

Agent's Signature: _____ Agent Code: _____ Date: _____

Form No. 149276-Receipt

Applicant Copy

**COMBINED INSURANCE COMPANY OF AMERICA**

**Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010.**
**Benefit Plans A, F and N are offered by Combined***

**YOU PURCHASED PLAN:**

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A and either Plan C or F available. Some plans may not be available in your state. [Plans E, H, I and J are no longer available for sale.]

**BASIC BENEFITS:**

- **Hospitalization**: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses**: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient department services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood**: First three pints of blood each year.
- **Hospice** – Part A coinsurance.

| **A*** | B | C | D | **F* F**** | G |
|---|---|---|---|---|---|
| **Basic, including 100% Part B coinsurance** | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance | **Basic, including 100% Part B coinsurance** | Basic, including 100% Part B coinsurance |
| | | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | **Skilled Nursing Facility Coinsurance** | Skilled Nursing Facility Coinsurance |
| | Part A Deductible | Part A Deductible | Part A Deductible | **Part A Deductible** | Part A Deductible |
| | | Part B Deductible | | **Part B Deductible** | |
| | | | | **Part B Excess (100%)** | Part B Excess (100%) |
| | | Foreign Travel Emergency | Foreign Travel Emergency | **Foreign Travel Emergency** | Foreign Travel Emergency |

| K | L | M | **N*** |
|---|---|---|---|
| Hospitalization and preventative care paid at 100%; other basic benefits paid at 50% | Hospitalization and preventative care paid at 100%; other basic benefits paid at 75% | Basic, including 100% Part B coinsurance | **Basic, including 100% Part B coinsurance except up to $20 copayment for office visit, and up to $50 copayment for ER** |
| 50% Skilled Nursing Facility Coinsurance | 75% Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | **Skilled Nursing Facility Coinsurance** |
| 50% Part A Deductible | 75% Part A Deductible | 50% Part A Deductible | **Part A Deductible** |
| | | | |
| | | | |
| | | Foreign Travel Emergency | **Foreign Travel Emergency** |
| Out-of-pocket limit $[4,620] paid at 100% after limit reached | Out-of-pocket limit $[2,310] paid at 100% after limit reached | | |

**Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,000] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

## DISCLOSURES

Use this outline to compare benefits and premiums among policies.

**This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. [Plans E, H, I, and J are no longer available for sale.]**

## READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

## RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to [111 East Wacker Drive • Suite 700 • Chicago, Illinois 60601.] If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

## POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

## NOTICE

This policy may not fully cover all of your medical costs.

Neither Combined Insurance Company of America nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

## COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

**Combined Insurance Company of America**
**Medicare Supplement**

## ARKANSAS

**Annual Standard Rates for All Zip Codes**

### PREMIUM INFORMATION

We, Combined Insurance Company of America, can only raise your premium if we raise the premium for all policies like yours in this State. Premiums are expected to increase each year but there is no increase due to your older age.

| | Non-Tobacco Rates | | | Tobacco Rates | | |
|---|---|---|---|---|---|---|
| | Form No. 14910 Plan A | Form No. 14911 Plan F | Form No. 14912 Plan N | Form No. 14910 Plan A | Form No. 14911 Plan F | Form No. 14912 Plan N |
| Issue Age | | | | | | |
| All Ages | $1,325.68 | $1,922.03 | $1,345.43 | $1,531.80 | $2,220.86 | $1,554.61 |

Policies may be issued on an annual, semi-annual or monthly mode.
Annual Premium Conversion Factor: Semi-Annual = 0.52, Monthly Pre-Authorized Check = 0.09

**Combined Insurance Company of America**
**Medicare Supplement**

## ARKANSAS

**Monthly Standard Rates for All Zip Codes**

| Issue Age | Non-Tobacco Rates | | | Tobacco Rates | | |
|---|---|---|---|---|---|---|
| | Form No. 14910 Plan A | Form No. 14911 Plan F | Form No. 14912 Plan N | Form No. 14910 Plan A | Form No. 14911 Plan F | Form No. 14912 Plan N |
| All Ages | $119.31 | $172.98 | $121.09 | $137.86 | $199.88 | $139.91 |

Policies may be issued on an annual, semi-annual or monthly mode.
Annual Premium Conversion Factor: Semi-Annual = 0.52, Monthly Pre-Authorized Check = 0.09

| **MEDICARE (PART A)<br>HOSPITAL SERVICES - PER BENEFIT PERIOD** | ***A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.** | | | | |
|---|---|---|---|---|---|
| **SERVICES** | **MEDICARE PAYS** | **PLAN A PAYS** | **YOU PAY** | **PLAN F PAYS** | **YOU PAY** |
| **HOSPITALIZATION*** Semi-private room and board, general nursing and miscellaneous services and supplies<br>First 60 days | All but $[1,100] | $0 | $[1,100] (Part A Deductible) | $[1,100] (Part A Deductible) | $0 |
| 61st through 90th day | All but $[275] a day | $[275] a day | $0 | $[275] a day | $0 |
| 91st day and after:<br>- While using 60 lifetime reserve days | All but $[550] a day | $[550] a day | $0 | $[550] a day | $0 |
| - Once lifetime reserve days are used:<br>- Additional 365 days | $0 | 100% of Medicare Eligible Expenses | $0** | 100% of Medicare Eligible Expenses | $0** |
| - Beyond the Additional 365 days | $0 | $0 | All Costs | $0 | All Costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital<br>First 20 days | All approved amounts | $0 | $0 | $0 | $0 |
| 21st through 100th day | All but $ [137.50] a day | $0 | Up to $[137.50] a day | Up to $[137.50] a day | $0 |
| 101st day and after | $0 | $0 | All Costs | $0 | All Costs |
| **BLOOD** First 3 pints | $0 | 3 pints | $0 | 3 pints | $0 |
| Additional Amounts | 100% | $0 | $0 | $0 | $0 |
| **HOSPICE CARE**<br>You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment /co-insurance for out-patient drugs and inpatient respite care | Medicare copayment / coinsurance | $0 | Medicare copayment / coinsurance | $0 |

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

| **MEDICARE (PART B)**<br>**MEDICAL SERVICES - PER CALENDAR YEAR** | ***Once you have been billed $[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your part B Deductible will have been met for the calendar year.** | | | | |
|---|---|---|---|---|---|
| **SERVICES** | **MEDICARE PAYS** | **PLAN A PAYS** | **YOU PAY** | **PLAN F PAYS** | **YOU PAY** |
| **MEDICAL EXPENSES -** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment<br>First $[155] of Medicare Approved Amounts* | $0 | $0 | $[155] (Part B Deductible) | $[155] (Part B Deductible) | $0 |
| Remainder of Medicare Approved Amounts | Generally 80% | Generally 20% | $0 | Generally 20% | $0 |
| **Part B Excess Charges**<br>(Above Medicare Approved Amounts) | $0 | $0 | All Costs | 100% | $0 |
| **BLOOD** First 3 pints | $0 | All Costs | $0 | All Costs | $0 |
| Next $[155] of Medicare Approved Amounts* | $0 | $0 | $[155] (Part B Deductible) | $[155] (Part B Deductible) | $0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 | $0 | $0 |

| **PARTS A & B** | **MEDICARE PAYS** | **PLAN A PAYS** | **YOU PAY** | **PLAN F PAYS** | **YOU PAY** |
|---|---|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies | 100% | $0 | $0 | $0 | $0 |
| - Durable medical equipment<br>First $[155] of Medicare Approved Amounts* | $0 | $0 | $[155] (Part B Deductible) | $[155] (Part B Deductible) | $0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 | 20% | $0 |

| **OTHER BENEFITS NOT COVERED BY MEDICARE** | **MEDICARE PAYS** | **PLAN A PAYS** | **YOU PAY** | **PLAN F PAYS** | **YOU PAY** |
|---|---|---|---|---|---|
| **FOREIGN TRAVEL - NOT COVERED BY MEDICARE**<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA<br>First $250 each calendar year | $0 | $0 | All Costs | $0 | $250 |
| Remainder of Charges | $0 | $0 | All Costs | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

| **MEDICARE (PART A)**<br>**HOSPITAL SERVICES - PER BENEFIT PERIOD** | ***A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.** | | |
|---|---|---|---|
| **SERVICES** | **MEDICARE PAYS** | **PLAN N PAYS** | **YOU PAY** |
| **HOSPITALIZATION*** Semi-private room and board, general nursing and miscellaneous services and supplies<br>First 60 days | All but $[1,100] | $[1,100] (Part A Deductible) | $0 |
| 61st through 90th day | All but $[275] a day | $[275] a day | $0 |
| 91st day and after:<br>- While using 60 lifetime reserve days | All but $[550] a day | $[550] a day | $0 |
| - Once lifetime reserve days are used:<br>- Additional 365 days | $0 | 100% of Medicare Eligible Expenses | $0** |
| Beyond the Additional 365 days | $0 | $0 | All Costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital<br>First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $ [137.50] a day | Up to $[137.50] a day | $0 |
| 101st day and after | $0 | $0 | All Costs |
| **BLOOD** First 3 pints | $0 | 3 pints | $0 |
| Additional Amounts | 100% | $0 | $0 |
| **HOSPICE CARE**<br>You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited co-payment /coinsurance for out-patient drugs and inpatient respite care | Medicare copayment / coinsurance | $0 |

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

| **MEDICARE (PART B)**<br>**MEDICAL SERVICES - PER CALENDAR YEAR** | ***Once you have been billed $[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your part B Deductible will have been met for the calendar year.** | | |
|---|---|---|---|
| **SERVICES** | **MEDICARE PAYS** | **PLAN N PAYS** | **YOU PAY** |
| **MEDICAL EXPENSES -** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[155] of Medicare Approved Amounts* | $0 | $0 | $[155] (Part B Deductible) |
| Remainder of Medicare Approved Amounts | Generally 80% | Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. | Up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. |
| **Part B Excess Charges** (Above Medicare Approved Amounts) | $0 | $0 | All Costs |
| **BLOOD** First 3 pints | $0 | All Costs | $0 |
| Next $[155] of Medicare Approved Amounts* | $0 | $0 | $[155] (Part B Deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

| **PARTS A & B** | **MEDICARE PAYS** | **PLAN N PAYS** | **YOU PAY** |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE APPROVED SERVICES<br>- Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| - Durable Medical Equipment<br>First $[155] of Medicare Approved Amounts* | $0 | $0 | $[155] (Part B Deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |

| **OTHER BENEFITS NOT COVERED BY MEDICARE** | **MEDICARE PAYS** | **PLAN N PAYS** | **YOU PAY** |
|---|---|---|---|
| **FOREIGN TRAVEL - NOT COVERED BY MEDICARE**<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA, First $250 each calendar year | $0 | $0 | $250 |
| Remainder of Charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |


# VARIABILITY MEMORANDUM

## Medicare Supplement Policy Form Nos. 14910-AR-A, 14911-AR-F, 14912-AR-N

| | |
|---|---|
| Company Addresses | Bracketed to allow for future change without re-filing. |
| Company Telephone Number | Bracketed to allow for future change without re-filing. |
| Officer Signatures | Bracketed to allow for future change without re-filing. |
| Eligibility | Bracketed to allow for future change without re-filing. |
| Notice of Claim | Bracketed to allow for future change of Third Party Administrator address without refiling the policy. |

## Outline of Coverage Form No. 014910

| | |
|---|---|
| The language "Plans E, H, I, and J are no longer available for sale." located on Page 1 in the first paragraph and on Page 2 under Disclosures. | Bracketed so that language can be removed on June 1, 2011without re-filing. |
| Rates | Bracketed to allow for future change without re-filing outline when new rates are approved by the Department. |
| Co-payments and Deductibles | Bracketed to allow for change without re-filing when co-payments and deductibles are updated. |

## Application Form No. 149276-AR

| | |
|---|---|
| Page 1 - Company Addresses | Bracketed to allow for future change without re-filing. |
| Page 1 – Bar Code Number | |
| Page 1 - Application Number | |
| Page 1 - Language Preference | |
| Page 1 - Call Type Address | |
| Page 1 - Plan Applying For | |
| Page 1 - Premium Mode | |
| Page 4 - Agent Information | |
| Page 5 - Automatic Premium Collection | Bracketed so that it may be removed without re-filing if the Company decides not to implement APC. |

## Replacement Notice Form No. RN031020R

| | |
|---|---|
| Company Addresses | Bracketed to allow for future change without re-filing. |

# MEDICARE SUPPLEMENT POLICY - PLAN A

**Combined Insurance Company of America**
A Legal Reserve Stock Corporation
(herein called Combined)
[Home Office and Policyholder Service Center
111 East Wacker Drive • Suite 700 • Chicago, Illinois 60601]
[1-800-544-5531]

## IMPORTANT NOTICE

Please read the copy of the application attached to this policy. Carefully check the application and write to the company, Combined Insurance Company of America, [5050 Broadway, Chicago, Illinois 60640], within 10 days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the policy and the policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

## GUIDE TO POLICY PROVISIONS



NOTICE TO BUYER: THE POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

Combined agrees to pay you, the Insured named in the Schedule, the benefits of this policy and any riders attached to it, subject to all the terms and limitations of this policy and any riders. This policy is issued in consideration of the statements made in the application and the payment of the initial premium.

## 30 DAY RIGHT TO EXAMINE POLICY

**Please read this policy. If you are not satisfied with this policy for any reason, return it to Combined's Home Office or the agent who sold it within 30 days of the date it is delivered. Any premium paid will be returned to you and this policy will be deemed void from the beginning.**

## GUARANTEED RENEWABLE

Combined guarantees that it will renew this policy for your lifetime. It will continue in force so long as the premium then in effect is paid on or before the due date or within the grace period. Combined reserves the right to change the premium. Any change in premium must be made on all policies of the same class.

Cost sharing amounts under Medicare will be changed automatically to coincide with any applicable changes in the Medicare deductible and co-payment percentage factors. Combined has the right to adjust the premium to correspond with such changes.

Combined will notify you in writing of any premium change at least 30 days before the effective date of the change.

## DEFINITIONS

"Benefit Period" means a period starting on the first day of covered Hospital confinement, and ending on the 60th consecutive day you are not confined in a Hospital (as defined by Medicare).

"Calendar Year" means the period from January 1st through December 31st.

"Coinsurance" means that part that you have to pay of the posthospital Skilled Nursing Facility Care expenses recognized as reasonable by Medicare.

"Doctor" means a licensed practitioner of the healing arts as defined by Medicare, acting within the scope of his or her license.

"Hospital" means an institution which is defined as such by Medicare. It does not include any facility not covered by Medicare.

"Injury" means a bodily injury due to an accident.

"Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

**"**Medicare Eligible Expenses" are expenses of the kinds covered by Medicare Parts A and B. They must be recognized as reasonable and medically necessary by Medicare.

"Sickness" means bodily illness or disease diagnosed or treated by a Doctor after the Effective Date.

## BASIC BENEFITS

**Medicare Parts A and B**
Combined will pay you during any benefit period for an Injury or Sickness which requires you to be Hospital confined for a Medicare approved treatment while this policy is in force.

In each Calendar Year, Combined will pay you Part B Eligible Expenses for Medicare approved treatment of a covered Injury or Sickness.

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
6. Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

## EXCLUSIONS

Benefits will not be paid for: (a) services rendered by or covered by any agency of a State government (except Medicaid) when you have no obligation to pay for such services; or (b) expenses covered and payable under Medicare.

## UNIFORM PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between the Insured and Combined. No change in this policy will be effective until approved by an executive officer of Combined. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** Misstatements in the Application: After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred after the expiration of such 2 year period.

**GRACE PERIOD:** This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force.

**REINSTATEMENT:** If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by Combined (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If Combined or its agent requires an application for reinstatement and the application is approved, the policy will be reinstated as of the approval date.

The reinstated policy will cover only such hospitalization or treatment that starts after the date of reinstatement. In all other respects the rights of the Insured and Combined will remain the same.

**NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Combined at [P.O. Box 638, Bellingham, Washington 98227-0638] or to Combined's agent. Combined will accept notice from a Medicare Part B carrier on claims submitted on the Insured's behalf by physicians and suppliers or the Explanation of Medicare Benefits (EOMB). Notice should include the name of the Insured and the policy number.

**CLAIM FORMS:** When Combined receives the notice of claim, it will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of loss requirements by giving Combined a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

**PROOFS OF LOSS:** If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Combined within 90 days after the end of each period for which Combined is liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, Combined shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless the claimant was legally incapacitated.

**TIME OF PAYMENT OF CLAIMS:** After receiving written proof of loss, Combined will pay immediately all benefits then due.

**PAYMENT OF CLAIMS:** Benefits will be paid to the Insured. Any benefits unpaid at death will be paid to the deceased's Insured's estate.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** Combined at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

**LEGAL ACTIONS:** No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after 3 years from the time written proof of loss is required to be given.

**MISSTATEMENT OF AGE:** If your age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.

**CONFORMITY WITH STATE STATUTES:** Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which the Insured resides on that date is amended to conform to the minimum requirements of such laws.

## GENERAL PROVISIONS

**EFFECTIVE DATE:** This policy takes effect and terminates at 12:01 A.M., Standard Time, at the place where you reside. It is effective on the Effective Date shown on the Schedule. Premium due dates, policy anniversaries and policy years shall be computed from the Effective Date.

**EXTENSION OF BENEFITS:** Termination of the policy shall be without prejudice to a continuous loss which commenced while this policy was in force, but the extension of benefits is conditioned upon the continuous total disability of the Insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

**REFUND OF UNEARNED PREMIUM:** Upon your death any proceeds payable will include a refund of premium paid for this policy for any period beyond the end of the policy month in which death occurred.

**MEDICAID ENTITLEMENT AFTER POLICY EFFECTIVE DATE:** If you apply for and are determined to be eligible for benefits under Title XIX of the Social Security Act ("Medicaid"), you may have the benefits and premiums under this policy suspended while you are so eligible, for up to twenty-four (24) months. You must notify Combined within 90 days after you become so eligible for Medicaid.

If you suspend the benefits and premiums as described above and then lose entitlement to Medicaid, this policy will be reinstituted, effective on the date of Medicaid termination if: (1) you notify Combined within 90 days of such loss of assistance; and (2) pay the required premium. The premium and coverage will be as favorable as if the policy was not suspended. There will be no waiting period for pre-existing conditions.

In Witness Whereof, Combined has caused this policy to be signed by our Chairman and Secretary.
[

Chairman and
Chief Executive Officer]

Secretary

## SCHEDULE

Insured: _____ Effective Date: _____

Policy Form Number: _____ Initial Premium $ _____

Policy Number: _____ Plan _____

## ELIGIBILITY

Eligible persons are those eligible for Medicare and who are insurable in accordance with Combined's underwriting standards. However, if the eligible person is enrolled in Medicare Part B, is age 65 and applies for this policy within 6 months from his or her 65th birthdate, issuance of this policy is guaranteed. Policy issuance is also guaranteed if the person is over age 65 and applies for this coverage within the first [6] months of Medicare Part B enrollment.

## MEDICARE SUPPLEMENT POLICY

# MEDICARE SUPPLEMENT POLICY - PLAN F

**Combined Insurance Company of America**
A Legal Reserve Stock Corporation
(herein called Combined)
[Home Office and Policyholder Service Center
111 East Wacker Drive • Suite 700 • Chicago, Illinois 60601]
[1-800-544-5531]

## IMPORTANT NOTICE

Please read the copy of the application attached to this policy. Carefully check the application and write to the company, Combined Insurance Company of America, [5050 Broadway, Chicago, Illinois 60640], within 10 days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the policy and the policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

## GUIDE TO POLICY PROVISIONS



NOTICE TO BUYER: THE POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

Combined agrees to pay you, the Insured named in the Schedule, the benefits of this policy and any riders attached to it, subject to all the terms and limitations of this policy and any riders. This policy is issued in consideration of the statements made in the application and the payment of the initial premium.

## 30 DAY RIGHT TO EXAMINE POLICY

**Please read this policy. If you are not satisfied with this policy for any reason, return it to Combined's Home Office or the agent who sold it within 30 days of the date it is delivered. Any premium paid will be returned to you and this policy will be deemed void from the beginning.**

## GUARANTEED RENEWABLE

Combined guarantees that it will renew this policy for your lifetime. It will continue in force so long as the premium then in effect is paid on or before the due date or within the grace period. Combined reserves the right to change the premium. Any change in premium must be made on all policies of the same class.

Cost sharing amounts under Medicare will be changed automatically to coincide with any applicable changes in the Medicare deductible and co-payment percentage factors. Combined has the right to adjust the premium to correspond with such changes.

Combined will notify you in writing of any premium change at least 30 days before the effective date of the change.

Form No. 14911-AR-F

## DEFINITIONS

"Benefit Period" means a period starting on the first day of covered Hospital confinement, and ending on the 60th consecutive day you are not confined in a Hospital (as defined by Medicare).

"Calendar Year" means the period from January 1st through December 31st.

"Coinsurance" means that part that you have to pay of the posthospital Skilled Nursing Facility Care expenses recognized as reasonable by Medicare.

"Doctor" means a licensed practitioner of the healing arts as defined by Medicare, acting within the scope of his or her license.

"Hospital" means an institution which is defined as such by Medicare. It does not include any facility not covered by Medicare.

"Injury" means a bodily injury due to an accident.

"Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

**"**Medicare Eligible Expenses" are expenses of the kinds covered by Medicare Parts A and B. They must be recognized as reasonable and medically necessary by Medicare.

"Sickness" means bodily illness or disease diagnosed or treated by a Doctor after the Effective Date.

## BASIC BENEFITS

**Medicare Parts A and B**
Combined will pay you during any benefit period for an Injury or Sickness which requires you to be Hospital confined for a Medicare approved treatment while this policy is in force.

In each Calendar Year, Combined will pay you Part B Eligible Expenses for Medicare approved treatment of a covered Injury or Sickness.

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B Deductible.
6. Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

## ADDITIONAL BENEFITS

**Medicare Part A Deductible**

When a covered Injury or Sickness requires you to be Hospital confined for Medicare approved treatment while the policy is in force, Combined will pay one hundred percent (100%), during any one Benefit Period, the cost you incur for the Medicare Part A inpatient Hospital deductible.

**Skilled Nursing Facility Care**

When a covered Injury or Sickness requires you to be confined in a Skilled Nursing Facility for skilled nursing care, Combined will pay the Medicare posthospital Skilled Nursing Facility Care actual billed charges up to the co-insurance amount for the 21st day to the 100th covered day of such confinement. The confinement must begin within 30 days of a covered Hospital confinement of at least three (3) consecutive days. Your Doctor must recommend and you must receive the care for the further treatment of the same or related Injury or Sickness for which you were hospitalized.

"Skilled Nursing Facility" is a facility that provides Skilled Nursing Care and: (a) is approved by Medicare for payment of Medicare Part A benefits; or (b) is qualified to receive such Medicare approval, if requested.

"Skilled Nursing Care" is care that is or would be recognized as Skilled Nursing Care under Medicare Part A based on the Medicare criteria in force at the time the care is received.

**Medicare Part B Deductible**

In each Calendar Year during which you incur Medicare Part B Eligible Expenses for the Medicare approved treatment of a covered Injury or Sickness and the treatment occurs while the policy is in force, Combined will pay one hundred percent (100%) of the cost you incur for the Medicare Part B deductible.

**Medicare Part B Excess Charges**

In each Calendar Year during which you incur Medicare Part B Eligible Expenses for the Medicare approved treatment of a covered Injury or Sickness and the treatment occurs while the policy is in force, Combined will pay one hundred percent (100%) of the difference between the Medicare Part B Eligible Expenses and the amount charged by the doctor which can be no greater than the limiting charge allowed by Medicare.

**Medically Necessary Emergency Care In a Foreign Country**

To the extent not covered by Medicare, Combined will pay eighty percent (80%) of billed charges for Medicare Eligible Expenses for medically necessary emergency Hospital, Doctor and medical care received in a foreign country, if: (1) the care would have been covered by Medicare if provided in the United States; and (2) the care began during the first sixty (60) consecutive days of each trip outside the United States.

This benefit is subject to: (1) a two hundred fifty dollar ($250) Calendar Year deductible; and (2) a lifetime maximum benefit of fifty thousand dollars ($50,000).

For purposes of this section, "Emergency Care" means care needed immediately because of an Injury or Sickness of sudden and unexpected onset.

## EXCLUSIONS

Benefits will not be paid for: (a) services rendered by or covered by any agency of a State government (except Medicaid) when you have no obligation to pay for such services; or (b) expenses covered and payable under Medicare.

## UNIFORM PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between the Insured and Combined. No change in this policy will be effective until approved by an executive officer of Combined. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** Misstatements in the Application: After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred after the expiration of such 2 year period.

**GRACE PERIOD:** This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force.

**REINSTATEMENT:** If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by Combined (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If Combined or its agent requires an application for reinstatement and the application is approved, the policy will be reinstated as of the approval date.

The reinstated policy will cover only such hospitalization or treatment that starts after the date of reinstatement. In all other respects the rights of the Insured and Combined will remain the same.

**NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Combined at [P.O. Box 638, Bellingham, Washington 98227-0638] or to Combined's agent. Combined will accept notice from a Medicare Part B carrier on claims submitted on the Insured's behalf by physicians and suppliers or the Explanation of Medicare Benefits (EOMB). Notice should include the name of the Insured and the policy number.

**CLAIM FORMS:** When Combined receives the notice of claim, it will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of loss requirements by giving Combined a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

**PROOFS OF LOSS:** If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Combined within 90 days after the end of each period for which Combined is liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, Combined shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless the claimant was legally incapacitated.

**TIME OF PAYMENT OF CLAIMS:** After receiving written proof of loss, Combined will pay immediately all benefits then due.

**PAYMENT OF CLAIMS:** Benefits will be paid to the Insured. Any benefits unpaid at death will be paid to the deceased's Insured's estate.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** Combined at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

**LEGAL ACTIONS:** No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after 3 years from the time written proof of loss is required to be given.

**MISSTATEMENT OF AGE:** If your age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.

**CONFORMITY WITH STATE STATUTES:** Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which the Insured resides on that date is amended to conform to the minimum requirements of such laws.

## GENERAL PROVISIONS

**EFFECTIVE DATE:** This policy takes effect and terminates at 12:01 A.M., Standard Time, at the place where you reside. It is effective on the Effective Date shown on the Schedule. Premium due dates, policy anniversaries and policy years shall be computed from the Effective Date.

**EXTENSION OF BENEFITS:** Termination of the policy shall be without prejudice to a continuous loss which commenced while this policy was in force, but the extension of benefits is conditioned upon the continuous total disability of the Insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

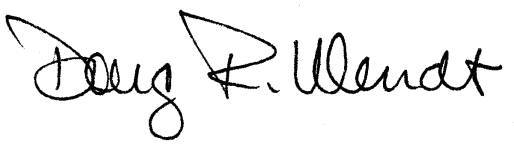
**REFUND OF UNEARNED PREMIUM:** Upon your death any proceeds payable will include a refund of premium paid for this policy for any period beyond the end of the policy month in which death occurred.

**MEDICAID ENTITLEMENT AFTER POLICY EFFECTIVE DATE:** If you apply for and are determined to be eligible for benefits under Title XIX of the Social Security Act ("Medicaid"), you may have the benefits and premiums under this policy suspended while you are so eligible, for up to twenty-four (24) months. You must notify Combined within 90 days after you become so eligible for Medicaid.

If you suspend the benefits and premiums as described above and then lose entitlement to Medicaid, this policy will be reinstituted, effective on the date of Medicaid termination if: (1) you notify Combined within 90 days of such loss of assistance; and (2) pay the required premium. The premium and coverage will be as favorable as if the policy was not suspended. There will be no waiting period for pre-existing conditions.

In Witness Whereof, Combined has caused this policy to be signed by our Chairman, President and Secretary.

[



Chairman and
Chief Executive Officer]

Secretary

## SCHEDULE

Insured: _____ Effective Date: _____

Policy Number: _____ Initial Premium: $ _____

Policy Form Number: _____ Plan: _____

## ELIGIBILITY

Eligible persons are those eligible for Medicare and who are insurable in accordance with Combined's underwriting standards. However, if the eligible person is enrolled in Medicare Part B, is age 65 and applies for this policy within 6 months from his or her 65th birthdate, issuance of this policy is guaranteed. Policy issuance is also guaranteed if the person is over age 65 and applies for this coverage within the first [6] months of Medicare Part B enrollment.

## MEDICARE SUPPLEMENT POLICY

# MEDICARE SUPPLEMENT POLICY - PLAN N


**Combined Insurance Company of America**
A Legal Reserve Stock Corporation
(herein called Combined)
[Home Office and Policyholder Service Center
111 East Wacker Drive • Suite 700 • Chicago, Illinois 60601]
[1-800-544-5531]

## IMPORTANT NOTICE

Please read the copy of the application attached to this policy. Carefully check the application and write to the company, Combined Insurance Company of America, [5050 Broadway, Chicago, Illinois 60640], within 10 days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the policy and the policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

## GUIDE TO POLICY PROVISIONS



NOTICE TO BUYER: THE POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

Combined agrees to pay you, the Insured named in the Schedule, the benefits of this policy and any riders attached to it, subject to all the terms and limitations of this policy and any riders. This policy is issued in consideration of the statements made in the application and the payment of the initial premium.

## 30 DAY RIGHT TO EXAMINE POLICY

**Please read this policy. If you are not satisfied with this policy for any reason, return it to Combined's Home Office or the agent who sold it within 30 days of the date it is delivered. Any premium paid will be returned to you and this policy will be deemed void from the beginning.**

## GUARANTEED RENEWABLE

Combined guarantees that it will renew this policy for your lifetime. It will continue in force so long as the premium then in effect is paid on or before the due date or within the grace period. Combined reserves the right to change the premium. Any change in premium must be made on all policies of the same class.

Cost sharing amounts under Medicare will be changed automatically to coincide with any applicable changes in the Medicare deductible and copayment percentage factors. Combined has the right to adjust the premium to correspond with such changes.

Combined will notify you in writing of any premium change at least 30 days before the effective date of the change.

## DEFINITIONS

"Benefit Period" means a period starting on the first day of covered Hospital confinement, and ending on the 60th consecutive day you are not confined in a Hospital (as defined by Medicare).

"Calendar Year" means the period from January 1st through December 31st.

"Coinsurance" means that part that you have to pay of the posthospital Skilled Nursing Facility Care expenses recognized as reasonable by Medicare.

"Doctor" means a licensed practitioner of the healing arts as defined by Medicare, acting within the scope of his or her license.

"Hospital" means an institution which is defined as such by Medicare. It does not include any facility not covered by Medicare.

"Injury" means a bodily injury due to an accident.

"Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

**"**Medicare Eligible Expenses" are expenses of the kinds covered by Medicare Parts A and B. They must be recognized as reasonable and medically necessary by Medicare.

"Sickness" means bodily illness or disease diagnosed or treated by a Doctor after the Effective Date.

## BASIC BENEFITS

**Medicare Parts A and B**
Combined will pay you during any benefit period for an Injury or Sickness which requires you to be Hospital confined for a Medicare approved treatment while this policy is in force.

In each Calendar Year, Combined will pay you Part B Eligible Expenses for Medicare approved treatment of a covered Injury or Sickness.

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period.
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.
5. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B Deductible.
6. Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

In each Calendar Year during which you incur Medicare Part B Eligible Expenses for Medicare approved treatment of a covered Injury or Sickness and the treatment occurs while the policy is in force, Combined will pay: 1) 100% of the cost you incur for the first 3 pints of unreplaced blood; and 2) the Medicare Part B Eligible Expenses not payable by Medicare after the deductible has been satisfied or in the case of hospital outpatient department services paid under a prospective payment system, with copayment in the following amounts: a) the lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and b) the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, the copayment shall be waived if you are admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

## ADDITIONAL BENEFITS

**Medicare Part A Deductible**

When a covered Injury or Sickness requires you to be Hospital confined for Medicare approved treatment while the policy is in force, Combined will pay one hundred percent (100%), during any one Benefit Period, the cost you incur for the Medicare Part A inpatient Hospital deductible.

**Skilled Nursing Facility Care**

When a covered Injury or Sickness requires you to be confined in a Skilled Nursing Facility for skilled nursing care, Combined will pay the Medicare posthospital Skilled Nursing Facility Care actual billed charges up to the coinsurance amount for the 21st day to the 100th covered day of such confinement. The confinement must begin within 30 days of a covered Hospital confinement of at least three (3) consecutive days. Your Doctor must recommend and you must receive the care for the further treatment of the same or related Injury or Sickness for which you were hospitalized.

"Skilled Nursing Facility" is a facility that provides Skilled Nursing Care and: (a) is approved by Medicare for payment of Medicare Part A benefits; or (b) is qualified to receive such Medicare approval, if requested.

"Skilled Nursing Care" is care that is or would be recognized as Skilled Nursing Care under Medicare Part A based on the Medicare criteria in force at the time the care is received.

**Medically Necessary Emergency Care in a Foreign Country**

To the extent not covered by Medicare, Combined will pay eighty percent (80%) of billed charges for Medicare Eligible Expenses for medically necessary emergency Hospital, Doctor and medical care received in a foreign country, if: (1) the care would have been covered by Medicare if provided in the United States; and (2) the care began during the first sixty (60) consecutive days of each trip outside the United States.

This benefit is subject to: (1) a two hundred fifty dollar ($250) Calendar Year deductible; and (2) a lifetime maximum benefit of fifty thousand dollars ($50,000).

For purposes of this section, "Emergency Care" means care needed immediately because of an Injury or Sickness of sudden and unexpected onset.

## EXCLUSIONS

Benefits will not be paid for: (a) services rendered by or covered by any agency of a State government (except Medicaid) when you have no obligation to pay for such services; or (b) expenses covered and payable under Medicare.

## UNIFORM PROVISIONS

**ENTIRE CONTRACT; CHANGES:** This policy, with the application and attached papers, is the entire contract between the Insured and Combined. No change in this policy will be effective until approved by an executive officer of Combined. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

**TIME LIMIT ON CERTAIN DEFENSES:** Misstatements in the Application: After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred after the expiration of such 2 year period.

**GRACE PERIOD:** This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force.

**REINSTATEMENT:** If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by Combined (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this policy.

If Combined or its agent requires an application for reinstatement and the application is approved, the policy will be reinstated as of the approval date.

The reinstated policy will cover only such hospitalization or treatment that starts after the date of reinstatement. In all other respects the rights of the Insured and Combined will remain the same.

**NOTICE OF CLAIM:** Written notice of claim must be given within 60 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Combined at [P.O. Box 638, Bellingham, Washington 98227-0638] or to Combined's agent. Combined will accept notice from a Medicare Part B carrier on claims submitted on the Insured's behalf by physicians and suppliers or the Explanation of Medicare Benefits (EOMB). Notice should include the name of the Insured and the policy number.

**CLAIM FORMS:** When Combined receives the notice of claim, it will send the claimant forms for filing proof of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of loss requirements by giving Combined a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

**PROOFS OF LOSS:** If the policy provides for periodic payment for a continuing loss, written proof of loss must be given to Combined within 90 days after the end of each period for which Combined is liable. For any other loss, written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, Combined shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, the proof required must be given no later than 1 year from the time specified unless the claimant was legally incapacitated.

**TIME OF PAYMENT OF CLAIMS:** After receiving written proof of loss, Combined will pay immediately all benefits then due.

**PAYMENT OF CLAIMS:** Benefits will be paid to the Insured. Any benefits unpaid at death will be paid to the deceased's Insured's estate.

**PHYSICAL EXAMINATIONS AND AUTOPSY:** Combined at its expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

**LEGAL ACTIONS:** No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after 3 years from the time written proof of loss is required to be given.

**MISSTATEMENT OF AGE:** If your age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.

**CONFORMITY WITH STATE STATUTES:** Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which the Insured resides on that date is amended to conform to the minimum requirements of such laws.

## GENERAL PROVISIONS

**EFFECTIVE DATE:** This policy takes effect and terminates at 12:01 A.M., Standard Time, at the place where you reside. It is effective on the Effective Date shown on the Schedule. Premium due dates, policy anniversaries and policy years shall be computed from the Effective Date.

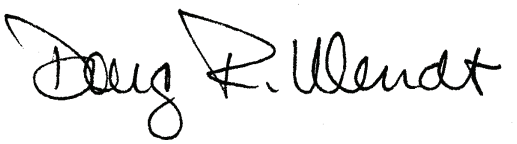
**EXTENSION OF BENEFITS:** Termination of the policy shall be without prejudice to a continuous loss which commenced while this policy was in force, but the extension of benefits is conditioned upon the continuous total disability of the Insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

**REFUND OF UNEARNED PREMIUM:** Upon your death any proceeds payable will include a refund of premium paid for this policy for any period beyond the end of the policy month in which death occurred.

**MEDICAID ENTITLEMENT AFTER POLICY EFFECTIVE DATE:** If you apply for and are determined to be eligible for benefits under Title XIX of the Social Security Act ("Medicaid"), you may have the benefits and premiums under this policy suspended while you are so eligible, for up to twenty-four (24) months. You must notify Combined within 90 days after you become so eligible for Medicaid.

If you suspend the benefits and premiums as described above and then lose entitlement to Medicaid, this policy will be reinstituted, effective on the date of Medicaid termination if: (1) you notify Combined within 90 days of such loss of assistance; and (2) pay the required premium. The premium and coverage will be as favorable as if the policy was not suspended. There will be no waiting period for pre-existing conditions.

In Witness Whereof, Combined has caused this policy to be signed by our Chairman and Secretary.
[



Chairman and
Chief Executive Officer]

Secretary

## SCHEDULE

Insured: _____ Effective Date: _____

Policy Form Number: _____ Initial Premium $ _____

Policy Number: _____ Plan _____

## ELIGIBILITY

Eligible persons are those eligible for Medicare and who are insurable in accordance with Combined's underwriting standards. However, if the eligible person is enrolled in Medicare Part B, is age 65 and applies for this policy within 6 months from his or her 65th birthdate, issuance of this policy is guaranteed. Policy issuance is also guaranteed if the person is over age 65 and applies for this coverage within the first [6] months of Medicare Part B enrollment.

## MEDICARE SUPPLEMENT POLICY

COMBINED INSURANCE COMPANY OF AMERICA
("Combined") [111 East Wacker Drive, Suite 700, Chicago, IL 60601]
I apply to Combined for a policy to be issued on the basis of the statement below:

[ 6001149276 ]

APPLICATION NUMBER [ 6 0 0 1 ]

## APPLICANT'S PERSONAL INFORMATION

M X F X INSURED'S FIRST NAME | MIDDLE INITIAL | LAST NAME

LANGUAGE PREFERENCE X E X S X F

INSURED'S RESIDENCE ADDRESS | RESIDENCE PHONE NUMBER

CITY | STATE | ZIP

INSURED'S DATE OF BIRTH (M M D D Y Y Y Y) | INSURED'S AGE

CALL TYPE ADDRESS: X Home X Business

INSURED'S BILLING ADDRESS IF DIFFERENT FROM RESIDENCE

CITY | STATE | ZIP

## PLAN SELECTION

**PLAN APPLYING FOR:** [ A X (14910) F X (14911) N X (14912) ]

**Do you have another Policy with Combined?** X YES X NO

REFERENCE CICA POLICY

RATE CLASS
Preferred X
Standard Non-Tobacco X
Standard Tobacco X

PLEASE INDICATE YOUR HEIGHT AND WEIGHT: INSURED'S HEIGHT ___ FT. ___ IN. INSURED'S WEIGHT ___ LBS.

PREMIUM COLLECTED
$ . (based on age on effective date)

PREMIUM MODE
Monthly APC X Semi-Annual X Annual X
Credit Card X

REQUESTED EFFECTIVE DATE (M M D D Y Y Y Y)

**If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.**

TO THE BEST OF MY KNOWLEDGE AND BELIEF: **(PLEASE ANSWER ALL QUESTIONS.)**

A. Did you turn age 65 in the last 6 months? X YES X NO

B. Did you or will you enroll in Medicare Part B within [6] months before or after the Date of Application? X YES X NO

C. Please indicate effective date of Medicare Part B: (M M D D Y Y Y Y) Medicare #
(Number on Medicare Card or Social Security Number)

D. 1. Do you have another Medicare Supplement policy in force? X YES X NO

2. Do you intend to replace your current Medicare supplement policy with this policy? X YES X NO
***(If "Yes" complete Replacement Form.)***

E. 1. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) X YES X NO

2. If so, what are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)
START (M M D D Y Y Y Y) END (M M D D Y Y Y Y)

F. If the answer to Question D or E is "YES", complete the following:

Company Name and Address | Type of Policy | Policy Number

**If you are applying under Open Enrollment or Guarantee Issue, please advance to Page 3 upon completion of above questions.**

**IF QUESTIONS A OR B ARE ANSWERED "YES", YOU DO NOT HAVE TO ANSWER HEALTH QUESTIONS G THROUGH J.**
**Please complete if applying during a Non-Open Enrollment or Non-Guarantee Issue Period.**

G. **Have you used any form of tobacco in the last 12 months?** YES NO

**IF ANY OF THE FOLLOWING QUESTIONS ARE ANSWERED "YES", THE APPLICANT IS UNINSURABLE.**

H. HAVE YOU RECEIVED ANY MEDICAL ADVICE INCLUDING REFERRALS FROM ANOTHER PHYSICIAN FOR DIAGNOSTIC TESTS OR SURGERY FROM A MEMBER OF THE MEDICAL PROFESSION OR TAKEN ANY MEDICATION IN THE PAST TWO YEARS FOR:

1. Stroke, TIA (Mini Stroke), Heart Attack, Congestive Heart Failure, Chronic Atrial Fibrillation or Coronary Artery Disease? YES NO
2. Cancer (excluding Skin Cancer), Leukemia, Hodgkins' Disease, Melanoma or any other type of Cancer? YES NO
3. Alzheimer's Disease, Dementia, Parkinson's Disease, Lou Gehrig's Disease/ALS, Multiple Sclerosis or Muscular Dystrophy? YES NO
4. Chronic Obstructive Pulmonary Disease, Chronic Bronchitis or Emphysema? YES NO
5. Manic Depression, Bipolar Disorder or Mental or Nervous Disorder requiring Psychiatric Care? YES NO
6. Alcoholism, Drug Addiction, Cirrhosis of the Liver, Kidney Failure or Insulin Dependent Diabetes? YES NO
7. Crippling or Debilitating Arthritis? YES NO
8. Oxygen Therapy, Kidney Dialysis, a Defibrillator, Pacemaker, Coronary Bypass Surgery, Angioplasty or Stent placement? YES NO
9. Diagnosis or treatment by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or tested positive for HIV? YES NO
10. Do you require or receive any assistance with any of your activities of daily living such as bathing, transferring, toileting, eating, dressing or continence? YES NO
11. Do you currently use any durable medical equipment such as a 4 prong cane, walker, wheelchair or motorized aid? YES NO

I. WITHIN THE PAST TWO (2) YEARS HAVE YOU HAD ANY MEDICAL ADVICE (INCLUDING REFERRALS TO OTHER PHYSICIANS FOR DIAGNOSTIC TESTS AND SURGERY) OR TREATMENT FROM A MEMBER OF THE MEDICAL PROFESSION OR TAKEN ANY PRESCRIPTION MEDICATION FOR ANY OTHER MEDICAL CONDITION(S) NOT LISTED ABOVE? YES NO

**(IF NO, PLEASE INCLUDE PRIMARY PHYSICIAN'S NAME, ADDRESS AND PHONE NUMBER)**

| MEDICAL CONDITION (If hospitalized, provide dates) | DATE OF DIAGNOSIS | TYPE OF TREATMENT if currently receiving treatment | PHYSICIAN NAME, ADDRESS (Street, City, State, Zip) AND PHONE NUMBER |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

J. PLEASE LIST ALL MEDICATIONS (PRESCRIPTION OR NON-PRESCRIPTION) YOU ARE CURRENTLY TAKING AND THE REASON FOR TAKING THEM IN THE SECTION BELOW:

| NAME OF MEDICATION | DOSAGE AND FREQUENCY PER DAY | MEDICAL CONDITION |
|---|---|---|
| | | |
| | | |
| | | |

**Please advance to Page 3 to complete questions K., L., M., and N.**

## OTHER COVERAGE INFORMATION

K. Are you covered for medical assistance through the state Medicaid program? X YES X NO
[NOTE TO APPLICANT: If you are participating in a "Spend-down Program" and have not met your "Share of Cost," please answer NO to this question]

If Yes,
(a) Will Medicaid pay your premiums for this Medicare supplement policy? X YES X NO

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? X YES X NO

L. Agents must list any other health insurance policies they have sold the applicant: (If None, state None)

1. List policies sold which are still in force. _____

2. List policies sold in the past five years which are no longer in force. _____

M. Are you applying for Guarantee Issue? ***(If "YES" please complete Question N and attach a copy of your termination notice, HIPAA certificate or other correspondence to validate your eligibility for open enrollment or guarantee issue.)*** X YES X NO

N. 1. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START M M D D Y Y Y Y END M M D D Y Y Y Y

2. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? X YES X NO

3. Was this your first time in this type of Medicare plan? X YES X NO

4. Did you drop a Medicare supplement policy to enroll in the Medicare plan? X YES X NO

---

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested within 90 days after losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

## AUTHORIZATION

To the best of my knowledge and belief, my answers are true and correct. I acknowledge receipt of the Outline of Coverage that describes the Policy for which I am applying, the pamphlet entitled, "Guide to Health Insurance for People with Medicare" and the Notice of Information Practices.

I authorize Combined Insurance Company of America or its reinsurers for the purpose of evaluating this application for insurance to acquire, review, research the release of information from the following: Medical Professional; Hospital; Physician; Medical Practitioner; Clinic; Pharmacy; Pharmacy Benefits Manager or other pharmacy-related services organization; Health Plan; other medical or medically-related facilities; Government Agency; Medical Information Bureau, Inc., (MIB); Consumer Reporting Agency; Combined's own records. Combined Insurance Company of America will acquire through a personal phone interview or another means from the above any needed information on the Insured, his/her dependents including but not limited to copies of records, concerning advice, care or treatment, on past or present health, the use of drugs or alcohol, and information relating to mental illness. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to any doctor, the Medical Information Bureau, Inc. or any other insurance company in order to evaluate a claim or an application for insurance.

This authorization will remain valid for a period of two years from the application date of the policy. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to you or your representative upon request to Combined.

You may revoke this authorization at any time by writing Combined; however, such revocation may affect coverage.

Failure to sign this authorization may impair the ability of Combined to evaluate or process this application and may be a basis for denying this application.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

An Authorized Interviewer may call to obtain additional information required to complete this application. Check most convenient time to call and provide telephone number(s) where you can be reached:

X Primary Phone Number (  ) _____ X Secondary Phone Number (  ) _____

X 6:30 am - 8:00 am X 8:00 am - 12:00 pm X 12:00 pm - 3:00 pm X 3:00 pm - 6:00 pm X After 6:00 pm

---

X _____ Date of Application: M M D D Y Y Y Y

Signature of Insured

City (where signed): _____ State: _____

[ _____ _____ Date: M M D D Y Y Y Y ]

Agent's/Producer's Signature Agent Code

Primary Agent/Producer contact information

| |
|---|
| Agent's/Producer's phone |
| Agent's/Producer's e-mail address |
| Agent's/Producer's cell phone |

Home Office use only

| Complete this area when splitting commissions. | |
|---|---|
| Primary | Secondary |
| Agent/Producer Name | Agent/Producer Name |
| Code # | Code # |
| Percentage | Percentage |
| Agent's/Producer's Signature | Agent's/Producer's Signature |

[ 6005149276 ]

APPLICATION NUMBER [6 0 0 5]

**AUTOMATIC PREMIUM COLLECTION**
**(Automatic Premium for Monthly Mode ONLY)**

Name of Financial Institution: City: State:

BANK ROUTING NUMBER BANK ACCOUNT NUMBER

NAME OF PAYOR APPEARING ON BANK/FINANCIAL INSTITUTION

**Complete if adding policies from another application**

Charge my Checking X Savings X Initial Premium Collected $

**Policy Type** →
(L = Life, H = Health)

Credit Card X

Preferred Billing Date (1–28 only)

Amount Charged

NAME OF CARDHOLDER CARDHOLDER ZIP CODE

ACCOUNT NUMBER EXPIRES MONTH YEAR CARD TYPE VISA X MC X

**AUTHORIZATION FOR ELECTRONIC DEBIT**

I hereby authorize Combined Insurance Company ("Combined"), to initiate electronic debit entries or effect a change by any other commercially accepted method, to my checking or savings account indicated above in the financial institution named above, hereinafter called Depository, to debit the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification from me of its termination in such time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it.

I understand that if any listed policy contains a premium and benefit increase provision, future premiums will increase as indicated in the policy Premium and Benefit schedule.

I agree that if premiums are not paid within the grace period under the subject policy(ies), as in the event withdrawals are dishonored, the policy(ies) will terminate. Life policies may have non-forfeiture benefits.

PAYOR'S PHONE NUMBER

X Date: MM DD YYYY

Signature of Payor (Signature must be the same as on file at the bank/financial institution)

| Application No. | | Amount of Insurance | $ |
|---|---|---|---|

**COMBINED INSURANCE COMPANY OF AMERICA • [111 East Wacker Drive • Suite 700 • Chicago, IL 60601]**

## MEDICARE SUPPLEMENT INSURANCE APPLICATION RECEIPT

I have applied for an insurance policy from Combined Insurance Company of America (Combined). With my application I have submitted a check, money order or cash in the amount of $_____. This receipt shall be void and no coverage applied for will not take affect if any check, draft or money order given in payment of the first premium is not honored.

I understand that this payment will be held by Combined and, if my application is approved and a policy is issued to me, Combined will accept this payment and apply it as the premium for the first period of coverage under the policy.

I understand that this policy will **NOT** become effective unless my application is approved in writing by Combined and a policy is delivered to me. I understand that if Combined approves my application, I will have coverage beginning on the date of such approval by Combined. If my application is not approved by Combined, the above premium will be refunded to me within 60 days of denial. I understand that in no event will I have coverage for the period between today and the date on which Combined approves or disapproves my application.

Proposed Insured's Signature: _____ Date: _____

Agent's Signature: _____ Agent Code: _____ Date: _____

Form No. 149276-Receipt

Home Office Copy
(remains with application)

APPLICATION NUMBER [6 0 0 5]

[ 6005149276 ]

**AUTOMATIC PREMIUM COLLECTION**
**(Automatic Premium for Monthly Mode ONLY)**

Name of Financial Institution: City: State:

BANK ROUTING NUMBER BANK ACCOUNT NUMBER

**Complete if adding policies from another application**

NAME OF PAYOR APPEARING ON BANK/FINANCIAL INSTITUTION

Charge my Checking X Savings X Initial Premium Collected $ **Policy Type** (L = Life, H = Health) →

Credit Card X Preferred Billing Date (1–28 only) Amount Charged

NAME OF CARDHOLDER CARDHOLDER ZIP CODE

ACCOUNT NUMBER EXPIRES MONTH YEAR CARD TYPE VISA X MC X

**AUTHORIZATION FOR ELECTRONIC DEBIT**

I hereby authorize Combined Insurance Company ("Combined"), to initiate electronic debit entries or effect a change by any other commercially accepted method, to my checking or savings account indicated above in the financial institution named above, hereinafter called Depository, to debit the same to such account. This authority is to remain in full force and effect until Combined and Depository have each received written notification from me of its termination in such time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it.

I understand that if any listed policy contains a premium and benefit increase provision, future premiums will increase as indicated in the policy Premium and Benefit schedule.

I agree that if premiums are not paid within the grace period under the subject policy(ies), as in the event withdrawals are dishonored, the policy(ies) will terminate. Life policies may have non-forfeiture benefits.

PAYOR'S PHONE NUMBER

X Date: M M D D Y Y Y Y

Signature of Payor (Signature must be the same as on file at the bank/financial institution)

| Application No. | | Amount of Insurance | $ |
|---|---|---|---|

**COMBINED INSURANCE COMPANY OF AMERICA • [111 East Wacker Drive • Suite 700 • Chicago, IL 60601]**

## MEDICARE SUPPLEMENT INSURANCE APPLICATION RECEIPT

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I understand that this payment will be held by Combined and, if my application is approved and a policy is issued to me, Combined will accept this payment and apply it as the premium for the first period of coverage under the policy.

I understand that this policy will **NOT** become effective unless my application is approved in writing by Combined and a policy is delivered to me. I understand that if Combined approves my application, I will have coverage beginning on the date of such approval by Combined. If my application is not approved by Combined, the above premium will be refunded to me within 60 days of denial. I understand that in no event will I have coverage for the period between today and the date on which Combined approves or disapproves my application.

Proposed Insured's Signature: _____ Date: _____

Agent's Signature: _____ Agent Code: _____ Date: _____

Form No. 149276-Receipt

Applicant Copy

**COMBINED INSURANCE COMPANY OF AMERICA**

**Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010.**
**Benefit Plans A, F and N are offered by Combined***

**YOU PURCHASED PLAN:**

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A and either Plan C or F available. Some plans may not be available in your state. [Plans E, H, I and J are no longer available for sale.]

**BASIC BENEFITS:**

- **Hospitalization**: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses**: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient department services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood**: First three pints of blood each year.
- **Hospice** – Part A coinsurance.

| **A*** | B | C | D | **F* F**** | G |
|---|---|---|---|---|---|
| **Basic, including 100% Part B coinsurance** | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance | **Basic, including 100% Part B coinsurance** | Basic, including 100% Part B coinsurance |
| | | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | **Skilled Nursing Facility Coinsurance** | Skilled Nursing Facility Coinsurance |
| | Part A Deductible | Part A Deductible | Part A Deductible | **Part A Deductible** | Part A Deductible |
| | | Part B Deductible | | **Part B Deductible** | |
| | | | | **Part B Excess (100%)** | Part B Excess (100%) |
| | | Foreign Travel Emergency | Foreign Travel Emergency | **Foreign Travel Emergency** | Foreign Travel Emergency |

| K | L | M | **N*** |
|---|---|---|---|
| Hospitalization and preventative care paid at 100%; other basic benefits paid at 50% | Hospitalization and preventative care paid at 100%; other basic benefits paid at 75% | Basic, including 100% Part B coinsurance | **Basic, including 100% Part B coinsurance except up to $20 copayment for office visit, and up to $50 copayment for ER** |
| 50% Skilled Nursing Facility Coinsurance | 75% Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | **Skilled Nursing Facility Coinsurance** |
| 50% Part A Deductible | 75% Part A Deductible | 50% Part A Deductible | **Part A Deductible** |
| | | | |
| | | | |
| | | Foreign Travel Emergency | **Foreign Travel Emergency** |
| Out-of-pocket limit $[4,620] paid at 100% after limit reached | Out-of-pocket limit $[2,310] paid at 100% after limit reached | | |

**Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2,000] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed [$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

## DISCLOSURES

Use this outline to compare benefits and premiums among policies.

**This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. [Plans E, H, I, and J are no longer available for sale.]**

## READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

## RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to [111 East Wacker Drive • Suite 700 • Chicago, Illinois 60601.] If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

## POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

## NOTICE

This policy may not fully cover all of your medical costs.

Neither Combined Insurance Company of America nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

## COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

**Combined Insurance Company of America**
**Medicare Supplement**

## ARKANSAS

**Annual Standard Rates for All Zip Codes**

### PREMIUM INFORMATION

We, Combined Insurance Company of America, can only raise your premium if we raise the premium for all policies like yours in this State. Premiums are expected to increase each year but there is no increase due to your older age.

| | Non-Tobacco Rates | | | Tobacco Rates | | |
|---|---|---|---|---|---|---|
| | Form No. 14910 Plan A | Form No. 14911 Plan F | Form No. 14912 Plan N | Form No. 14910 Plan A | Form No. 14911 Plan F | Form No. 14912 Plan N |
| Issue Age | | | | | | |
| All Ages | $1,325.68 | $1,922.03 | $1,345.43 | $1,531.80 | $2,220.86 | $1,554.61 |

Policies may be issued on an annual, semi-annual or monthly mode.
Annual Premium Conversion Factor: Semi-Annual = 0.52, Monthly Pre-Authorized Check = 0.09

**Combined Insurance Company of America**
**Medicare Supplement**

## ARKANSAS

**Monthly Standard Rates for All Zip Codes**

| Issue Age | Non-Tobacco Rates | | | Tobacco Rates | | |
|---|---|---|---|---|---|---|
| | Form No. 14910 Plan A | Form No. 14911 Plan F | Form No. 14912 Plan N | Form No. 14910 Plan A | Form No. 14911 Plan F | Form No. 14912 Plan N |
| All Ages | $119.31 | $172.98 | $121.09 | $137.86 | $199.88 | $139.91 |

Policies may be issued on an annual, semi-annual or monthly mode.
Annual Premium Conversion Factor: Semi-Annual = 0.52, Monthly Pre-Authorized Check = 0.09

| **MEDICARE (PART A)<br>HOSPITAL SERVICES - PER BENEFIT PERIOD** | ***A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.** | | | | |
|---|---|---|---|---|---|
| **SERVICES** | **MEDICARE PAYS** | **PLAN A PAYS** | **YOU PAY** | **PLAN F PAYS** | **YOU PAY** |
| **HOSPITALIZATION*** Semi-private room and board, general nursing and miscellaneous services and supplies<br>First 60 days | All but $[1,100] | $0 | $[1,100] (Part A Deductible) | $[1,100] (Part A Deductible) | $0 |
| 61st through 90th day | All but $[275] a day | $[275] a day | $0 | $[275] a day | $0 |
| 91st day and after:<br>- While using 60 lifetime reserve days | All but $[550] a day | $[550] a day | $0 | $[550] a day | $0 |
| - Once lifetime reserve days are used:<br>- Additional 365 days | $0 | 100% of Medicare Eligible Expenses | $0** | 100% of Medicare Eligible Expenses | $0** |
| - Beyond the Additional 365 days | $0 | $0 | All Costs | $0 | All Costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital<br>First 20 days | All approved amounts | $0 | $0 | $0 | $0 |
| 21st through 100th day | All but $ [137.50] a day | $0 | Up to $[137.50] a day | Up to $[137.50] a day | $0 |
| 101st day and after | $0 | $0 | All Costs | $0 | All Costs |
| **BLOOD** First 3 pints | $0 | 3 pints | $0 | 3 pints | $0 |
| Additional Amounts | 100% | $0 | $0 | $0 | $0 |
| **HOSPICE CARE**<br>You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited copayment /co-insurance for out-patient drugs and inpatient respite care | Medicare copayment / coinsurance | $0 | Medicare copayment / coinsurance | $0 |

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

| **MEDICARE (PART B)**<br>**MEDICAL SERVICES - PER CALENDAR YEAR** | ***Once you have been billed $[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your part B Deductible will have been met for the calendar year.** | | | | |
|---|---|---|---|---|---|
| **SERVICES** | **MEDICARE PAYS** | **PLAN A PAYS** | **YOU PAY** | **PLAN F PAYS** | **YOU PAY** |
| **MEDICAL EXPENSES -** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment<br>First $[155] of Medicare Approved Amounts* | $0 | $0 | $[155] (Part B Deductible) | $[155] (Part B Deductible) | $0 |
| Remainder of Medicare Approved Amounts | Generally 80% | Generally 20% | $0 | Generally 20% | $0 |
| **Part B Excess Charges**<br>(Above Medicare Approved Amounts) | $0 | $0 | All Costs | 100% | $0 |
| **BLOOD** First 3 pints | $0 | All Costs | $0 | All Costs | $0 |
| Next $[155] of Medicare Approved Amounts* | $0 | $0 | $[155] (Part B Deductible) | $[155] (Part B Deductible) | $0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 | $0 | $0 |

| **PARTS A & B** | **MEDICARE PAYS** | **PLAN A PAYS** | **YOU PAY** | **PLAN F PAYS** | **YOU PAY** |
|---|---|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies | 100% | $0 | $0 | $0 | $0 |
| - Durable medical equipment<br>First $[155] of Medicare Approved Amounts* | $0 | $0 | $[155] (Part B Deductible) | $[155] (Part B Deductible) | $0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 | 20% | $0 |

| **OTHER BENEFITS NOT COVERED BY MEDICARE** | **MEDICARE PAYS** | **PLAN A PAYS** | **YOU PAY** | **PLAN F PAYS** | **YOU PAY** |
|---|---|---|---|---|---|
| **FOREIGN TRAVEL - NOT COVERED BY MEDICARE**<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA<br>First $250 each calendar year | $0 | $0 | All Costs | $0 | $250 |
| Remainder of Charges | $0 | $0 | All Costs | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

| **MEDICARE (PART A)**<br>**HOSPITAL SERVICES - PER BENEFIT PERIOD** | ***A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.** | | |
|---|---|---|---|
| **SERVICES** | **MEDICARE PAYS** | **PLAN N PAYS** | **YOU PAY** |
| **HOSPITALIZATION*** Semi-private room and board, general nursing and miscellaneous services and supplies<br>First 60 days | All but $[1,100] | $[1,100] (Part A Deductible) | $0 |
| 61st through 90th day | All but $[275] a day | $[275] a day | $0 |
| 91st day and after:<br>- While using 60 lifetime reserve days | All but $[550] a day | $[550] a day | $0 |
| - Once lifetime reserve days are used:<br>- Additional 365 days | $0 | 100% of Medicare Eligible Expenses | $0** |
| Beyond the Additional 365 days | $0 | $0 | All Costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital<br>First 20 days | All approved amounts | $0 | $0 |
| 21st through 100th day | All but $ [137.50] a day | Up to $[137.50] a day | $0 |
| 101st day and after | $0 | $0 | All Costs |
| **BLOOD** First 3 pints | $0 | 3 pints | $0 |
| Additional Amounts | 100% | $0 | $0 |
| **HOSPICE CARE**<br>You must meet Medicare's requirements, including a doctor's certification of terminal illness | All but very limited co-payment /coinsurance for out-patient drugs and inpatient respite care | Medicare copayment / coinsurance | $0 |

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

| MEDICARE (PART B)<br>MEDICAL SERVICES - PER CALENDAR YEAR | *Once you have been billed $[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your part B Deductible will have been met for the calendar year. | | |
|---|---|---|---|
| **SERVICES** | **MEDICARE PAYS** | **PLAN N PAYS** | **YOU PAY** |
| **MEDICAL EXPENSES -** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[155] of Medicare Approved Amounts* | $0 | $0 | $[155] (Part B Deductible) |
| Remainder of Medicare Approved Amounts | Generally 80% | Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. | Up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. |
| **Part B Excess Charges** (Above Medicare Approved Amounts) | $0 | $0 | All Costs |
| **BLOOD** First 3 pints | $0 | All Costs | $0 |
| Next $[155] of Medicare Approved Amounts* | $0 | $0 | $[155] (Part B Deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** - TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

| **PARTS A & B** | **MEDICARE PAYS** | **PLAN N PAYS** | **YOU PAY** |
|---|---|---|---|
| **HOME HEALTH CARE** MEDICARE APPROVED SERVICES<br>- Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| - Durable Medical Equipment<br>First $[155] of Medicare Approved Amounts* | $0 | $0 | $[155] (Part B Deductible) |
| Remainder of Medicare Approved Amounts | 80% | 20% | $0 |

| **OTHER BENEFITS NOT COVERED BY MEDICARE** | **MEDICARE PAYS** | **PLAN N PAYS** | **YOU PAY** |
|---|---|---|---|
| **FOREIGN TRAVEL - NOT COVERED BY MEDICARE**<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA, First $250 each calendar year | $0 | $0 | $250 |
| Remainder of Charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

**COMBINED INSURANCE COMPANY OF AMERICA**
[111 East Wacker Drive • Suite 700 • Chicago, Illinois 60601]

# NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.**

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Combined Insurance Company of America. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT (BROKER OR OTHER REPRESENTATIVE):

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage Plan. The replacement policy is being purchased for the following reason (check one):

___ Additional benefits.
___ No change in benefits, but lower premiums.
___ Fewer benefits and lower premiums.
___ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
___ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

___ Other, (Please specify)_____

_____

_____

State law provides that your replacement policy or certificate may not contain new waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____ _____
(Signature of Agent, Broker or Other Representative) (Applicant's Signature)

_____ _____
Date

_____
(Typed Name and Address of Issuer, Agent, or Broker)